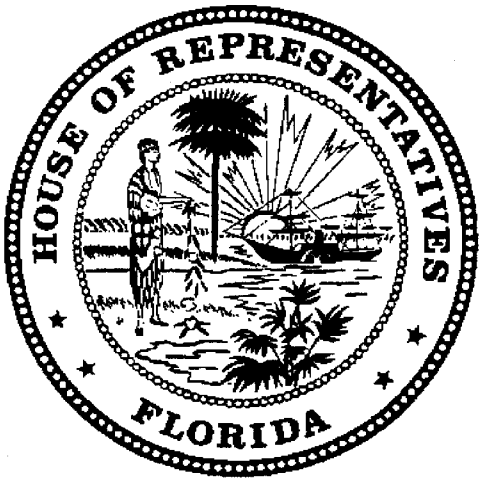

Health Care General Committee

Wednesday, March 22, 2006
9:00 AM – 12:00 PM
306 HOB

COMMITTEE MEETING PACKET

Allan G. Bense
Speaker

Gayle B. Harrell
Chair

AGENDA
Health Care General Committee
March 22, 2006
9:00 a.m. – 12:00 p.m.
306 HOB

I. Call to order/Roll Call

II. Opening Remarks

III. Consideration of the following bills:

- **HB 7063** - - Review under the Open Government Sunset Review Act regarding the Johnnie B. Byrd, Sr., Alzheimer's Center and Research Institute by Governmental Operations Committee
- **HB 783 CS** - - Wellness Programs for State Employees by Henriquez
- **HB 645** - - Nursing Home Facilities by Gelber
- **HB 699 CS** - - Health Care by Negron
- **HB 855** - - Dental Laboratories by Jordan

IV. Closing Remarks and Adjournment

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 645 Nursing Home Facilities
SPONSOR(S): Gelber
TIED BILLS: **IDEN./SIM. BILLS:** SB 298

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care General Committee		Brown-Barrios	Brown-Barrios
2) Domestic Security Committee			
3) Health Care Appropriations Committee			
4) Health & Families Council			
5)			

SUMMARY ANALYSIS

HB 645 requires the Agency for Health Care Administration (AHCA) to reimburse an eligible nursing home facility for the costs of building or modifying its emergency electrical power system capacity to fully operate the facility during and after an emergency when power is interrupted. To be eligible for reimbursement, a nursing home facility must:

- Not have been cited for a class I deficiency as defined in s. 400.23(8)(a), F.S., within the last 30 months preceding the application for reimbursement,
- Not be in the hurricane evacuation zone in its county,
- Have the capacity, as determined by AHCA, to receive transferred residents that are evacuated, and
- Agree to receive those transferred residents.

The AHCA estimates the fiscal impact of the bill to be $57 million (general revenue).

If enacted, the bill takes effect upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government – HB 645 requires AHCA to reimburse certain nursing homes for the installation cost of an emergency generator to fully operate the facility during and after an emergency when power is interrupted.

B. EFFECT OF PROPOSED CHANGES:

The bill creates s. 400.0627, F.S., to require the AHCA to reimburse nursing homes, meeting certain eligibility criteria, for the installation cost of an emergency generator to fully operate the facility due to a utility interruption during and after an emergency in order to remain fully operational and to provide care of residents evacuated from other nursing facilities. This installation would be additional to the existing installation and would not require the nursing home to modify the existing electrical system.

BACKGROUND

Hurricane Evacuation Zones

Hurricane evacuation zones are predetermined geographic areas that are likely to experience destruction or severe damage, from storm surge, waves, erosion, or flooding.[1] Depending on the track of the storm, the greater the intensity of a storm (Tropical to Category 5) the greater the geographic area that will experience these conditions and therefore need to be evacuated. The closer the nursing home is to the coast, the more likely that a nursing home will be located in an evacuation zone.

According to AHCA, there are 677 licensed nursing homes in Florida. During the 2005 hurricane season there were five recorded hurricanes which caused Florida evacuations. There were 21 nursing home facilities that were completely evacuated and four that were partially evacuated with a total of 1,795 patients being displaced. Only one nursing home facility was actually closed or became inactive during the entire 2005 season. There were 51 nursing home facilities that sustained some type of damage from the hurricanes. A total of 239 nursing home facilities lost power and switched to generators during the hurricane season with one additional nursing home facility losing power without the availability of a generator.[2]

AHCA estimates approximately 466 nursing facilities are not located in county hurricane evacuation zones. This represents approximately 57,000 nursing home beds or about 70% of capacity.

Requirements for Nursing Home Licensure - Essential Electrical System

Since July 1982, all nursing home facilities licensed under part II of ch. 400, F.S., have been required by rule to have an onsite Essential Electrical System (EES) with an onsite fuel supply of up to 64 hours.[3] The design, installation, operation, and maintenance of this EES is reviewed by AHCA.

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[1] According to NOAA, storm surge maps reflect the worst case hurricane storm surge inundation (including astronomical high tide), regardless of the point of where the center of the hurricane (or tropical storm) makes landfall. No single hurricane will necessarily cause all of the flooding represented on evacuation maps. The data reflect only still-water saltwater flooding and do not take into account the effects of pounding waves that ride on top of the storm surge in locations exposed to wave action. Evacuation maps do not show areas that may be flooded by excessive rainfall-they only depict flooding that would occur as a result of the ocean level rising as well as estuaries and rivers that can be affected by hurricane storm surge.

[2] Senate Staff Analysis and Economic Impact Statement SB 298, revised January 23, 2006

[3] FAC 59A-4.133. Of the 669 existing licensed nursing home facilities, there are 30 facilities constructed prior to 1982 that do not have an existing generator system. These facilities house only residents, who do not require any life support systems, and as such, these facilities are in compliance with all state and federal codes and standards through the use of a battery supplied emergency electrical system that supplies emergency power to the life safety components of the facility as required by NFPA 99 for 1-½ hours duration. These components include the fire alarm, nurse call, emergency egress lighting, exit lighting, and locking systems.

The EES supplies electrical service to the three main electrical branches, including the Life Safety branch, the Critical Branch, and the Equipment Branch within 10 seconds of normal service interruption. As required by the NFPA standards, these emergency electrical branches provide emergency electrical service to specified electrical components of the facility such as the fire alarm system, the nurse call system, the emergency egress lighting system, the exit lighting system, the magnetic door locking system, and selected critical convenience receptacles and equipment in the facility. In addition, since 1996, all new nursing home facilities and new additions to these facilities have been required to have an EES that supplies electrical power to all ventilating fans, ice making equipment, refrigeration equipment, and selected heating, ventilation, and air conditioning equipment as determined by the facility, for a period up to 72 hours of continuous service at actual load capacity of the generator.

The EES is not required to provide electrical service to the heating, ventilation, and air conditioning (HVAC) equipment of the facility nor to the general lighting or other electrical items not specifically required by the National Fire Protection Association codes and standards.

Class I Deficiency

Section 400.23, F.S., requires AHCA to evaluate all nursing home facilities and against standards and make a determination as to the degree of compliance by each licensee with the established standards adopted in rules. The agency bases its evaluation on the most recent inspection report, taking into consideration findings from other official reports, surveys, interviews, investigations, and inspections. Findings of deficient practice are classified according to the nature and the scope of the deficiency.

There are four classes of deficiencies:

- A class I deficiency is a deficiency in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility.
- A class II deficiency is a deficiency that has compromised a resident's ability to maintain or accomplish his or her highest practicable physical, mental, and psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.
- A class III deficiency is a deficiency that will result in no more than minimal physical, mental, or psychosocial discomfort to the resident or has the potential to compromise the resident's ability to maintain or accomplish his or her highest practical physical, mental, or psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.
- A class IV deficiency is a deficiency that will result in no more than a minor negative impact on the resident.

According to AHCA, data from the most recent 30-month period indicates that 47 facilities have received a Class I deficiency. The classification of a deficiency affects the licensure status of the facility. A conditional license is issued if a facility has one or more class I or class II deficiencies, or class III deficiencies not corrected within the time established by the Agency. In addition, a facility that is cited for a class I deficiency, two or more class II deficiencies arising from separate surveys or investigations within a 60-day period, or has had three or more substantiated complaints within a 6-month period, each resulting in at least one class I or class II deficiency, is placed on a 6-month survey cycle for the next 2-year period.

Evacuation and Transfer of Nursing Home Residents

Section 400.23(2)(g), F.S., requires AHCA to develop rules after consultation with the Department of Community Affairs that requires each nursing home to develop a comprehensive emergency management plan (CEMP). At a minimum, the rules must provide for plan components that address emergency evacuation transportation; adequate sheltering arrangements; postdisaster activities, including emergency power, food, and water; postdisaster transportation; supplies; staffing; emergency equipment; individual identification of residents and transfer of records; and responding to family inquiries. The comprehensive emergency management plan is subject to review and approval by the

local emergency management agency. During its review, the local emergency management agency must ensure that the following agencies, at a minimum, are given the opportunity to review the plan: the Department of Elder Affairs, the Department of Health, AHCA and the Department of Community Affairs. The local emergency management agency must complete its review within 60 days and either approves the plan or advices the facility of necessary revisions.

Rule 59A-4.126, F.A.C., incorporates by reference a publication (AHCA 3110-6006, March 1994) which lists the minimum criteria for a nursing home's CEMP. The CEMP must state the procedures to ensure that emergency power, whether natural gas or diesel, is supplied to the nursing home. If the fuel supply is natural gas, the plan must identify alternate means should loss of power occur that would affect the natural gas system. The plan must state the capacity of the emergency fuel system.

C. SECTION DIRECTORY:

Section 1. Creates s. 400.0627, F.S., to provide state financial assistance to eligible nursing homes to upgrade their emergency electrical power system capacity.

Section 2. This bill provides that an unspecified sum of money shall be appropriated during the 2006-07 fiscal year from the General Revenue Fund to AHCA for the purpose of reimbursing eligible nursing homes for building or modifying their emergency electrical power system capacity to fully operate during and after an emergency.

Section 3. Provides that the bill takes effect upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None

2. Expenditures:

   The bill appropriates an, as yet, unspecified sum from the General Revenue Fund to implement the provisions of this bill. According to AHCA, the average nursing home with 120 beds is about 50,000 square feet or about 400 square feet per bed. AHCA assumes that 47,700 nursing home beds out of a total of 84,000 beds will be eligible for this grant and if each bed requires approximately 400 square feet of building to house the bed and its support functions, there could be as much as 19 million square feet of building to supply with emergency electrical power if all eligible nursing homes took advantage of the program. Based on current estimates from the industry, AHCA estimates that the total cost to equip all of these facilities with a supplemental emergency electrical power system would cost an average of $3.00 per square foot or approximately $57 million.

   Using these assumptions an electrical generator and modifications for a 120 bed nursing home with 50,000 square feet of space would cost $150,000.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None

2. Expenditures:

   None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

If implemented the bill should have a positive economic effect on the business sector the sells, installs and provides maintenance for large electrical generators. Depending on the size of the facility, and decisions regarding how much of the facility's normal electric needs should be met by emergency electric generators, costs can vary widely. The cost for a large facility to purchase large fixed diesel generators that will automatically detect loss of grid power and immediately start up to provide uninterrupted emergency supplemental power to all of the facility's regular electrical needs can range from $10,000 to $100,000+. Maintenance costs for generators can also vary widely. Most generator manufacturers advise that generators be tested and run at least once monthly to ensure they will be operational when needed. Depending on the size of the generator, fuel costs can also vary widely.[4]

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or to take any action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None

B. RULE-MAKING AUTHORITY:

The bill does not provide specific rule authority however, s. 400.23(2), F.S., gives AHCA the authority to adopt and enforce rules to implement part II (related to nursing homes) of chapter 400, F.S.

C. DRAFTING ISSUES OR OTHER COMMENTS:

A key feature of the bill is to provide electrical generators to a nursing home so that the facility "can fully operate" during and after an emergency However, the bill does not define "fully operate".

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

[4] U.S. Department of Homeland Security, U. S. Coast Guard http://www.uscg.mil/hq/g-/mp/pdf/Best%20Practice%20Backup%20Generators.pdf:

A bill to be entitled

An act relating to nursing home facilities; creating s. 400.0627, F.S.; providing legislative intent; requiring the Agency for Health Care Administration to reimburse nursing home facilities for the cost of building or modifying their emergency electrical power systems to fully operate during and after an emergency; providing eligibility criteria for reimbursement; providing an appropriation; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 400.0627, Florida Statutes, is created to read:

400.0627 Emergency electrical power system capacity.--

(1) It is the intent of the Legislature that each nursing home facility in this state be encouraged to have an emergency electrical power system capacity that is sufficient to remain fully operational during and after an emergency in order to maintain the safety and health of the residents of the nursing home facility and, if necessary, to provide care to residents evacuated from other nursing home facilities.

(2) The agency shall reimburse an eligible nursing home facility for the costs of building or modifying its emergency electrical power system capacity to fully operate the facility during and after an emergency. To be eligible for reimbursement, a nursing home facility must:

(a) Not have been cited for any class I deficiency within

the 30 months preceding the application for reimbursement;

(b) Not be located within the hurricane evacuation zone of the county in which it is located;

(c) Have the capacity, as determined by the agency, to care for residents evacuated from other nursing home facilities during an emergency; and

(d) Agree to receive residents who are transferred from other nursing home facilities.

(3) This section does not require a nursing home facility to modify its existing emergency electrical power system capacity.

Section 2. The sum of $ is appropriated from the General Revenue Fund to the Agency for Health Care Administration for the purpose of reimbursing eligible nursing home facilities for the costs of building or modifying their emergency electrical power system capacity to fully operate the facility during and after an emergency during the 2006-2007 fiscal year.

Section 3. This act shall take effect upon becoming a law.

CHAMBER ACTION

The Health Care Regulation Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to health care; amending ss. 458.331 and 459.015, F.S.; authorizing the Board of Medicine and the Board of Osteopathic Medicine to establish by rule certain standards of practice and standards of care for physicians and osteopathic physicians who supervise licensed health care practitioners who are not under direct, onsite supervision by the supervising physician; providing exemptions; providing for such rules to apply equally to physician assistants and advanced registered nurse practitioners; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (dd) of subsection (1) of section 458.331, Florida Statutes, is amended to read:

458.331 Grounds for disciplinary action; action by the board and department.--

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(dd)1. Failing to supervise adequately the activities of those physician assistants, paramedics, emergency medical technicians, advanced registered nurse practitioners, or anesthesiologist assistants acting under the supervision of the physician.

2. Notwithstanding any other provision of this chapter, the board may establish by rule standards of practice and standards of care for physicians who supervise licensed health care practitioners in a facility that is not licensed under chapter 395, and who are not under direct, onsite supervision of a supervising physician, which may include:

a. The percentage of time a supervising physician spends directly supervising the licensed health care practitioners.

b. Standards for adequate supervision, including the standards for review of medical records and the allowable distance of the licensed health care practitioners from the supervising physician.

c. The number of each type of licensed health care practitioner that a supervising physician may supervise.

3. The standards established in the rules under subparagraph 2. may vary depending on the specialty of the physician, the type of licensed health care practitioner under supervision, and the practice setting.

4. The requirements of subparagraph 2. shall not apply to health care practitioners providing services in conjunction with a college of medicine; to health care practitioners providing

services in a nursing home licensed under part II of chapter 400, an assisted living facility licensed under part III of chapter 400, a continuing care facility licensed under chapter 651, or a retirement community consisting of independent living units and either a licensed nursing home or assisted living facility; or to health care practitioners providing services to a rural health network as defined in s. 381.0406 or to persons enrolled in a program designed to maintain elders and persons with disabilities in a home and community-based setting.

5. Any rule adopted pursuant to the authority granted under subparagraph 2. shall apply equally to physician assistants and advanced registered nurse practitioners.

Section 2. Paragraph (hh) of subsection (1) of section 459.015, Florida Statutes, is amended to read:

459.015 Grounds for disciplinary action; action by the board and department.--

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(hh)1. Failing to supervise adequately the activities of those physician assistants, paramedics, emergency medical technicians, advanced registered nurse practitioners, anesthesiologist assistants, or other persons acting under the supervision of the osteopathic physician.

2. Notwithstanding any other provision of this chapter, the board may establish by rule standards of practice and standards of care for osteopathic physicians who supervise licensed health care practitioners in a facility that is not licensed under chapter 395, and who are not under direct, onsite

supervision of a supervising osteopathic physician, which may include:

a. The percentage of time a supervising osteopathic physician spends directly supervising the licensed health care practitioners.

b. Standards for adequate supervision, including the standards for review of medical records and the allowable distance of the licensed health care practitioners from the supervising osteopathic physician.

c. The number of each type of licensed health care practitioner that a supervising osteopathic physician may supervise.

3. The standards established in the rules under subparagraph 2. may vary depending on the specialty of the osteopathic physician, the type of licensed health care practitioner under supervision, and the practice setting.

4. The requirements of subparagraph 2. shall not apply to health care practitioners providing services in conjunction with a college of medicine; to health care practitioners providing services in a nursing home licensed under part II of chapter 400, an assisted living facility licensed under part III of chapter 400, a continuing care facility licensed under chapter 651, or a retirement community consisting of independent living units and either a licensed nursing home or assisted living facility; or to health care practitioners providing services to a rural health network as defined in s. 381.0406 or to persons enrolled in a program designed to maintain elders and persons with disabilities in a home and community-based setting.

5. Any rule adopted pursuant to the authority granted under subparagraph 2. shall apply equally to physician assistants and advanced registered nurse practitioners.

Section 3. This act shall take effect upon becoming a law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 783 CS Wellness Programs for State Employees
SPONSOR(S): Henriquez
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 382

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Governmental Operations Committee	7 Y, 0 N, w/CS	Brown	Williamson
2) Health Care General Committee		Ciccone	Brown-Barrios
3) Fiscal Council			
4) State Administration Council			
5)			

SUMMARY ANALYSIS

The bill defines specific elements to be included in age-based and gender-based services provided by health maintenance organizations under contract to the state employee health insurance program. It also creates within the Department of Management Services the Florida State Employee Wellness Council, made up of nine members appointed by the Governor.

The council is created to provide health education information to employees and to help develop minimum benefits for health care providers when providing age-based and gender-based wellness benefits. The council has three specific duties:

- Work to encourage participation in wellness programs by state employees.
- Develop standards and criteria for age-based and gender-based wellness programs.
- Recommend a "healthy food and beverage" menu for food-service establishments in buildings owned, operated, or leased by the state.

The fiscal impact of the council is nominal. Certain aspects of the newly-defined health benefits may have an indeterminate effect on healthcare premiums paid by the state.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government – The bill creates a nine-member advisory council.

Promote personal responsibility – The bill defines certain benefits included in the health maintenance organization program that are intended to foster healthier behaviors in state employees.

B. EFFECT OF PROPOSED CHANGES:

Health Coverage - Background

The State of Florida provides a comprehensive array of workplace benefits to its employees and their spouses and dependents.[1] Full-time and part-time employees and retirees may choose between a preferred provider organization (PPO) or from one of several health maintenance organizations (HMOs) for their health insurance needs.[2] Employees who are eligible retired members from one of the branches of the United States Armed Services may choose a health care supplement (TRICARE) to complement their federal retiree benefits. The Department of Management Services, through its Division of State Group Insurance, negotiates all contracts with these providers.[3] The providers, however, own their respective networks or are the direct contractors for service delivery.

"Wellness" is a term used in s. 110.123, F.S., but it is not otherwise defined. In a wider sense wellness has come to mean an array of health care services that focus on chronic disease management or lifestyle changes that have direct or indirect health outcomes. Some of these services may be workplace based, as with blood pressure monitoring; home-based, as with changes to personal nutrition and portion control practices; or a combination of the two in which the employer provides subsidies or discounts with plan-affiliated vendors to achieve the same objectives. In this latter sense "wellness" is not part of the insurance contract per se but does serve the complementary objectives of provider and patient in promoting preventive techniques that stabilize employer compensation expenses, including direct benefit costs and compensated absences, and add to the quality of employee lives.

The PPO plan contains a feature called "Blue Complements" that provides access to the following discounted wellness services:[4]

- Alternative therapies;
- Discounted vision care;
- Discounted hearing care and appliances;
- Laser correction of vision impairments;
- Discounted fitness or athletic club membership;[5]
- Discounted bicycle helmets; and
- Discounted weight-loss management club memberships.

Each HMO decides individually how it will approach the concept of wellness. Wellness services provided by participating HMOs include:[6]

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[1] See generally s. 110.123, F.S.
[2] Section 110.123(3), F.S.
[3] Specific authority is granted in s. 110.123(5)(c), F.S.
[4] http://www.bcbsfl.com. The "Blue Complements" materials are directly available at http://www.bcbsfl.com/index.cfm?fuseaction=BlueComplements.Home
[5] Limited geographic accessibility.
[6] Accessible through www.myflorida.com/dsgi.

- AVMED: smoking cessation; weight management; live/recorded access to a health information service; and chronic disease management.
- CAPITAL HEALTH PLAN: chronic disease management specifically targeting diabetes and asthma; smoking cessation; weight loss; cholesterol/heart disease; newborn health care; nutrition; and cardio-pulmonary resuscitation (CPR).
- FLORIDA HEALTH CARE PLANS: automated links to sponsored health information web sites; smoking cessation; osteoporosis management; diabetes management; weight management; nutrition management; asthma management; bariatrics and sponsored exercise.
- TRICARE: weight loss; hearing; health screening.
- UNITED HEALTH CARE: on-line/live health assessments and information; chronic disease management; nutrition; and discounted vision, dental, alternative, smoking cessation, long-term care, fitness, and weight management.
- VISTA HEALTH PLANS: registration required; none listed.

Wellness benefits are broadly recognized as valuable adjuncts to health insurance plans and can stabilize the costs of an employer's direct benefits costs by reducing compensated absences, increasing productivity, and limiting the out-of-pocket expenses incurred by employees for health events that can be minimized by lifestyle changes. Current law provides premium rebates for insurance plans that can demonstrate a majority of enrollees participate in organized wellness programs.[7] The nominal indicators of measurement are smoking cessation, weight reduction, and body mass index.

A principal feature of the recently enacted Medicaid Choice program is the development of preventive care programs for eligible low-income individuals.[8] For enrollees who take advantage of these services and alter their lifestyles under physician guidance, there can be tangible financial effects through additional choices they will have in the selection of health benefits.

Health Coverage – Effect of Bill

The bill amends s. 110.123, F.S., to require that HMOs under contract to the state employee health insurance program provide enumerated age- and gender-based services. The named services include:

- Aerobic exercise;
- Education in alcohol and substance abuse prevention;
- Blood cholesterol screening;
- Health risk appraisals;
- Blood pressure screening and education;
- Nutrition education;
- Program planning;
- Safety belt education;
- Smoking cessation;
- Stress management;
- Weight management; and
- Women's health education.

Councils - Background

Section 20.03(7), F.S. defines a "council" or "advisory council" as an "advisory body created... to function on a continuing basis for the study of the problems arising in a specified... area... and to provide recommendations and policy alternatives." Councils must be established and maintained according to certain provisions, including:[9]

- A statutorily defined purpose;
- The appointment of members to 4-year staggered terms;

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[7] Section 627.65626, F.S.
[8] Section 409.91211, F.S.; Senate Bill 2-B; Chapter 2005-358, Laws of Florida.
[9] Section 20.052(4), F.S., *et seq.*

- Appointment of members by the governor, the head of a department, or a Cabinet officer; and
- Compliance with public meeting and public records requirements.

Councils – Effect of Bill

The bill adds a new subsection (13) to s. 110.123, F.S., to create the Florida State Employee Wellness Council. The council is composed of nine members appointed by the Governor for staggered 4-year terms. Its members must be state residents and must be active in the health and medical field. One member must be a state employee.

The council has three specific duties:

- Encourage state employee participation in wellness programs and prepare informational actions on this topic;
- Develop standards for age-based and gender-based programs; and
- Recommend a "healthy food and beverage menu" for food outlets in buildings owned, operated or leased by the State of Florida.

The council is directed to meet within 60 days after appointments are complete, and to meet at least quarterly thereafter. The Department of Management Services is directed to provide administrative support for the activities of the council.

C. SECTION DIRECTORY:

Section 1 amends s. 110.123, F.S., to include a detailed definition of "age-based and gender-based benefits," and to create a wellness council.

Section 2 provides an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The bill does not create, modify, amend, or eliminate a state revenue source.

2. Expenditures:

   The Florida State Employee Wellness Council is directed to meet at least once per calendar quarter. Travel and per diem for these meetings at $500 per member equals $18,000 annually. The Department of Management Services is directed to provide staff support. Absent any specific appropriation, the meeting costs will have to be assumed by the agency out of appropriated funds or, alternatively, assumed by the employers of the appointed members.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   The bill does not create, modify, amend, or eliminate a local revenue source.

2. Expenditures:

   The bill does not create, modify, amend, or eliminate a local expenditure.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

There is no direct impact to the contract vendors that operate food service establishments in state agency occupied buildings as the recommendations of the council on a model healthy menu are not

binding. This element could be a consideration in later negotiations of leases or subleases of such spaces where the State of Florida is the building owner.

The bill is nominally directed at HMOs, not the PPO. Many of these service elements are contained in current practices of these providers and are available directly or by referral. As wellness programs, under current law, are not necessarily part of the insurance coverage arrangements, a provider may make arrangements for their provision at the expense of the insured outside of the contract reimbursements. Employees enrolled in one of several pre-tax medical reimbursements or health savings accounts authorized under federal law may reduce their taxable expense for eligible services by paying for these items with pre-tax dollars.

D. FISCAL COMMENTS:

It is not entirely clear whether the enumerated benefits would result in an increased premium to be paid by state employers. The Division of State Group Insurance has stated that the additional definition "would have the effect of mandating benefits not currently a part of the benefit plan for State members."[10] However, virtually all of the "wellness" components are already part of the HMO providers' plans, as the components presumably lead to lower healthcare costs incurred by the providers.

Additionally, the complex negotiation involved in entering into HMO contracts means that the state may be able to leverage its enrollee size in order to receive these mandates at no increase in premium. These are "bargaining chips" that cannot be accounted for in great detail, in advance of the solicitation and negotiation of new benefits plans.

Wellness programs can have front-loaded effects but back-loaded benefits. Lifestyle changes require the passage of time for their effects to be fully realized. The changes also may not necessarily be linear. A person may adopt an alternative, healthier lifestyle for which the tangible benefits may accrue principally to the employer, such as in reduced absenteeism and increased productivity.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Other Comments – HMOs

As drafted, the bill applies only to the HMOs but not the PPO. The Department of Management Services negotiates multi-year contracts with its provider HMOs. Passage of a statute will not necessarily cause the contracts to be amended prior to their normal expiration unless both contracting parties consent to the specification of different services and the incidence of payment.

[10] *Department of Management Services' HB 783 Bill Analysis*, Director, Division of State Group Insurance, February 7, 2006.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On March 15, 2006, the Governmental Operations Committee adopted a strike-all amendment and reported the bill favorably with committee substitute (CS). The CS made the following changes:

- Amended the definition of "age-based and gender-based wellness benefits" to change the term "weight loss" to "weight management."
- Modified the membership of the Florida State Employee Wellness Council to ensure that at least one member is a current state employee.
- Included all health care providers, in addition to HMOs, within the council's scope.
- Made grammatical changes.

CHAMBER ACTION

The Governmental Operations Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to wellness programs for state employees; amending s. 110.123, F.S.; defining the term "aged-based and gender-based benefits" for purposes of the state group insurance program; creating the Florida State Employee Wellness Council within the Department of Management Services; providing for membership; providing for reimbursement of per diem and travel expenses; providing purpose and duties of the council; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (h) of subsection (3) of section 110.123, Florida Statutes, is amended, and subsection (13) is added to that section, to read:

110.123 State group insurance program.--

(3) STATE GROUP INSURANCE PROGRAM.--

(h)1. A person eligible to participate in the state group insurance program may be authorized by rules adopted by the department, in lieu of participating in the state group health insurance plan, to exercise an option to elect membership in a health maintenance organization plan which is under contract with the state in accordance with criteria established by this section and by said rules. The offer of optional membership in a health maintenance organization plan permitted by this paragraph may be limited or conditioned by rule as may be necessary to meet the requirements of state and federal laws.

2. The department shall contract with health maintenance organizations seeking to participate in the state group insurance program through a request for proposal or other procurement process, as developed by the Department of Management Services and determined to be appropriate.

a. The department shall establish a schedule of minimum benefits for health maintenance organization coverage, and that schedule shall include: physician services; inpatient and outpatient hospital services; emergency medical services, including out-of-area emergency coverage; diagnostic laboratory and diagnostic and therapeutic radiologic services; mental health, alcohol, and chemical dependency treatment services meeting the minimum requirements of state and federal law; skilled nursing facilities and services; prescription drugs; age-based and gender-based wellness benefits; and other benefits as may be required by the department. Additional services may be provided subject to the contract between the department and the HMO. As used in this paragraph, the term "age-based and gender-

based wellness benefits" includes aerobic exercise, education in alcohol and substance abuse prevention, blood cholesterol screening, health risk appraisals, blood pressure screening and education, nutrition education, program planning, safety belt education, smoking cessation, stress management, weight management, and woman's health education.

b. The department may establish uniform deductibles, copayments, coverage tiers, or coinsurance schedules for all participating HMO plans.

c. The department may require detailed information from each health maintenance organization participating in the procurement process, including information pertaining to organizational status, experience in providing prepaid health benefits, accessibility of services, financial stability of the plan, quality of management services, accreditation status, quality of medical services, network access and adequacy, performance measurement, ability to meet the department's reporting requirements, and the actuarial basis of the proposed rates and other data determined by the director to be necessary for the evaluation and selection of health maintenance organization plans and negotiation of appropriate rates for these plans. Upon receipt of proposals by health maintenance organization plans and the evaluation of those proposals, the department may enter into negotiations with all of the plans or a subset of the plans, as the department determines appropriate. Nothing shall preclude the department from negotiating regional or statewide contracts with health maintenance organization

plans when this is cost-effective and when the department determines that the plan offers high value to enrollees.

d. The department may limit the number of HMOs that it contracts with in each service area based on the nature of the bids the department receives, the number of state employees in the service area, or any unique geographical characteristics of the service area. The department shall establish by rule service areas throughout the state.

e. All persons participating in the state group insurance program may be required to contribute towards a total state group health premium that may vary depending upon the plan and coverage tier selected by the enrollee and the level of state contribution authorized by the Legislature.

3. The department is authorized to negotiate and to contract with specialty psychiatric hospitals for mental health benefits, on a regional basis, for alcohol, drug abuse, and mental and nervous disorders. The department may establish, subject to the approval of the Legislature pursuant to subsection (5), any such regional plan upon completion of an actuarial study to determine any impact on plan benefits and premiums.

4. In addition to contracting pursuant to subparagraph 2., the department may enter into contract with any HMO to participate in the state group insurance program which:

a. Serves greater than 5,000 recipients on a prepaid basis under the Medicaid program;

b. Does not currently meet the 25-percent non-Medicare/non-Medicaid enrollment composition requirement

established by the Department of Health excluding participants enrolled in the state group insurance program;

c. Meets the minimum benefit package and copayments and deductibles contained in sub-subparagraphs 2.a. and b.;

d. Is willing to participate in the state group insurance program at a cost of premiums that is not greater than 95 percent of the cost of HMO premiums accepted by the department in each service area; and

e. Meets the minimum surplus requirements of s. 641.225.

The department is authorized to contract with HMOs that meet the requirements of sub-subparagraphs a.-d. prior to the open enrollment period for state employees. The department is not required to renew the contract with the HMOs as set forth in this paragraph more than twice. Thereafter, the HMOs shall be eligible to participate in the state group insurance program only through the request for proposal or invitation to negotiate process described in subparagraph 2.

5. All enrollees in a state group health insurance plan, a TRICARE supplemental insurance plan, or any health maintenance organization plan have the option of changing to any other health plan that is offered by the state within any open enrollment period designated by the department. Open enrollment shall be held at least once each calendar year.

6. When a contract between a treating provider and the state-contracted health maintenance organization is terminated for any reason other than for cause, each party shall allow any enrollee for whom treatment was active to continue coverage and

care when medically necessary, through completion of treatment of a condition for which the enrollee was receiving care at the time of the termination, until the enrollee selects another treating provider, or until the next open enrollment period offered, whichever is longer, but no longer than 6 months after termination of the contract. Each party to the terminated contract shall allow an enrollee who has initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care and coverage until completion of postpartum care. This does not prevent a provider from refusing to continue to provide care to an enrollee who is abusive, noncompliant, or in arrears in payments for services provided. For care continued under this subparagraph, the program and the provider shall continue to be bound by the terms of the terminated contract. Changes made within 30 days before termination of a contract are effective only if agreed to by both parties.

7. Any HMO participating in the state group insurance program shall submit health care utilization and cost data to the department, in such form and in such manner as the department shall require, as a condition of participating in the program. The department shall enter into negotiations with its contracting HMOs to determine the nature and scope of the data submission and the final requirements, format, penalties associated with noncompliance, and timetables for submission. These determinations shall be adopted by rule.

8. The department may establish and direct, with respect to collective bargaining issues, a comprehensive package of

insurance benefits that may include supplemental health and life coverage, dental care, long-term care, vision care, and other benefits it determines necessary to enable state employees to select from among benefit options that best suit their individual and family needs.

a. Based upon a desired benefit package, the department shall issue a request for proposal or invitation to negotiate for health insurance providers interested in participating in the state group insurance program, and the department shall issue a request for proposal or invitation to negotiate for insurance providers interested in participating in the non-health-related components of the state group insurance program. Upon receipt of all proposals, the department may enter into contract negotiations with insurance providers submitting bids or negotiate a specially designed benefit package. Insurance providers offering or providing supplemental coverage as of May 30, 1991, which qualify for pretax benefit treatment pursuant to s. 125 of the Internal Revenue Code of 1986, with 5,500 or more state employees currently enrolled may be included by the department in the supplemental insurance benefit plan established by the department without participating in a request for proposal, submitting bids, negotiating contracts, or negotiating a specially designed benefit package. These contracts shall provide state employees with the most cost-effective and comprehensive coverage available; however, no state or agency funds shall be contributed toward the cost of any part of the premium of such supplemental benefit plans. With respect to dental coverage, the division shall include in any

solicitation or contract for any state group dental program made after July 1, 2001, a comprehensive indemnity dental plan option which offers enrollees a completely unrestricted choice of dentists. If a dental plan is endorsed, or in some manner recognized as the preferred product, such plan shall include a comprehensive indemnity dental plan option which provides enrollees with a completely unrestricted choice of dentists.

b. Pursuant to the applicable provisions of s. 110.161, and s. 125 of the Internal Revenue Code of 1986, the department shall enroll in the pretax benefit program those state employees who voluntarily elect coverage in any of the supplemental insurance benefit plans as provided by sub-subparagraph a.

c. Nothing herein contained shall be construed to prohibit insurance providers from continuing to provide or offer supplemental benefit coverage to state employees as provided under existing agency plans.

(13) FLORIDA STATE EMPLOYEE WELLNESS COUNCIL.--

(a) There is created within the department the Florida State Employee Wellness Council.

(b) The council shall be an advisory body to the department to provide health education information to employees and to assist the department in developing minimum benefits for all health care providers when providing age-based and gender-based wellness benefits.

(c) The council shall be composed of nine members appointed by the Governor. When making appointments to the council, the Governor shall appoint persons who are residents of the state and who are highly knowledgeable concerning, active

in, and recognized leaders in the health and medical field, at least one of whom must be an employee of the state. Council members shall equitably represent the broadest spectrum of the health industry and the geographic areas of the state. Not more than one member of the council may be from any one company, organization, or association.

(d)1. Council members shall be appointed to 4-year terms, except that the initial terms shall be staggered. The Governor shall appoint three members to 2-year terms, three members to 3-year terms, and three members to 4-year terms.

2. A member's absence from three consecutive meetings shall result in his or her automatic removal from the council. A vacancy on the council shall be filled for the remainder of the unexpired term.

(e) The council shall annually elect from its membership one member to serve as chair of the council and one member to serve as vice chair.

(f) The first meeting of the council shall be called by the chair not more than 60 days after the council members are appointed by the Governor. The council shall thereafter meet at least once quarterly and may meet more often as necessary. The department shall provide staff assistance to the council which shall include, but not be limited to, keeping records of the proceedings of the council and serving as custodian of all books, documents, and papers filed with the council.

(g) A majority of the members of the council constitutes a quorum.

(h) Members of the council shall serve without compensation, but are entitled to reimbursement for per diem and travel expenses as provided in s. 112.061 while performing their duties.

(i) The council shall:

1. Work to encourage participation in wellness programs by state employees. The council may prepare informational programs and brochures for state agencies and employees.

2. In consultation with the department, develop standards and criteria for age-based and gender-based wellness programs.

3. In consultation with the department, recommend a "healthy food and beverage" menu for cafeterias and other food-service establishments located in buildings owned, operated, or leased by the state.

Section 2. This act shall take effect July 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS - Revised

BILL #: HB 855 Dental Laboratories
SPONSOR(S): Jordan and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 948

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care General Committee		Brown-Barrios	Brown-Barrios
2) Health Care Regulation Committee			
3) Health Care Appropriations Committee			
4) Health & Families Council			
5)			

SUMMARY ANALYSIS

HB 855 requires Florida dentists to use only the services of registered dental laboratories for the purpose of constructing, altering, repairing, or duplicating any denture, partial denture, bridge splint, or orthodontic or prosthetic appliance. The bill requires dental laboratories operating or conducting business in Florida regardless of where they are located to register with the Department of Health (DOH) and comply with state law and applicable rules. The bill makes conforming changes in the procedures that must be followed to reflect this requirement. The bill requires that beginning July 1, 2009, a dental laboratory operating or conducting business in Florida employ at least one dental technician certified by the National Board for Certification in Dental Laboratory Technology.

If enacted, the bill takes effect July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government – The bill places additional requirements on Florida dentists, DOH and dental laboratories operating or conducting business in Florida.

B. EFFECT OF PROPOSED CHANGES:

Florida dentist could only use the services of registered dental laboratories for crowns, bridges, dentures, and other dental prosthetics work. Dental laboratories would need to employ at least one certified dental technician beginning July 1, 2009 and submit the documentation with it's biennially registration with DOH. Dental laboratories operating or conducting business in Florida regardless of where they are located would be required to register with DOH and comply with state law and applicable rules. DOH would need to conduct periodic inspections of dental laboratories operating or conducting business in Florida including dental laboratories that might be located in other states or countries.

BACKGROUND

Use of Unlicensed Person

Current law requires licensed dentists who use the services of any unlicensed person for constructing, altering, repairing, or duplicating any denture, partial denture, bridge splint, or orthodontic or prosthetic appliance to furnish a written work order to that person in a form prescribed by rule of the Board of Dentistry. A copy of the work order must be retained in a permanent file in the dentist's office for a period of four years, and the original work order must be retained in a permanent file for a period of two years by the unlicensed person in her or his place of business. The permanent file of work orders must be open for inspection at any reasonable time by DOH or its duly constituted agent. A dentist's failure to maintain permanent records of the work orders makes the dentist liable for a license revocation or suspension.[1]

Dental Laboratories

A dental laboratory is defined as:

> [A]ny person, firm, or corporation who performs for a fee of any kind, gratuitously, or otherwise, directly or through an agent or employee, by any means or method, or who in any way supplies or manufactures artificial substitutes for the natural teeth, or who furnishes, supplies, constructs, or reproduces or repairs any prosthetic denture, bridge, or appliance to be worn in the human mouth or who in any way holds itself out as a dental laboratory.[2]

The definition of dental laboratory excludes any dental laboratory technician who constructs or repairs dental prosthetic appliances in the office of a licensed dentist for such dentist only and under her or his supervision and work order.

Every dental laboratory operating in Florida must register with DOH every two years.[3] The registration fee is $200 and there are penalties for failure to comply with the registration requirements.[4] There are currently 1143 registered dental laboratories operating in the state. However, many out of state and out of country laboratories are currently being utilized by Florida dentists, and are not registered with

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[1] s. 466.021, F.S.
[2] s. 466.031, F.S.
[3] s. 466.032, F.S.
[4] F.A.C. 64B27-1.002

DOH because they are not operating in Florida.[5] DOH is required to perform periodic inspection of dental laboratories operating in the state but is not required to perform inspections for dental laboratories outside of Florida. Each dental laboratory must comply with practice requirements and a procedure delineated in rules and is subject to periodic inspections at least one time during each calendar year.[6] Eighteen legally sufficient complaints against dental laboratories were received by DOH in fiscal year 2004/05, mainly resulting from unsanitary conditions upon inspection by staff or expired dental laboratory licenses.[7]

DOH is prohibited from requiring an examination to operate as a dental laboratory, but is required to issue a registration certificate upon completion of the registration form and compliance with any rules promulgated by DOH.[8]

The federal Food and Drug Administration (FDA) regulates materials used and the manufacturing process but not the final product of dental laboratories. These regulations apply to any finished device intended for human use that is manufactured, imported, or offered for import in any state.[9] The 1997 Food and Drug Modernization Act, requires all foreign dental laboratories to register and list with the FDA.[10]

As with most market sectors, globalization is also affecting the U.S. dental laboratory market. Pressure to keep cost down is increasingly shifting dental laboratory work to offshore establishments. Foreign laboratories that cater to the U.S. market offer cost-effective pricing. Overseas laboratories charge fees that are typically one-half to two-thirds lower compared to U.S. dental laboratories. For some U.S. laboratory owners, out sourcing to overseas laboratories is an important factor in their ability to expand their laboratories or keep cost down.[11]

Dental Laboratory Technicians - Description of Occupation[12]
Dental laboratory technicians fill prescriptions from dentists for crowns, bridges, dentures, and other dental prosthetics. Nationally, dental laboratory technicians held about 47,000 jobs in 2002. Approximately 7 out of 10 jobs were in medical equipment and supply manufacturing laboratories, which usually are small, privately owned businesses with fewer than five employees. However, some laboratories are large; a few employ more than 50 technicians. Some dental laboratory technicians work in offices of dentists.

Most dental laboratory technicians learn their craft on the job. They begin with simple tasks, such as pouring plaster into an impression, and progress to more complex procedures, such as making porcelain crowns and bridges. Becoming a fully trained technician requires an average of 3 to 4 years.

Training in dental laboratory technology is also available through community and junior colleges, vocational-technical institutes, and the U.S. Armed Forces. Formal training programs vary greatly both in length and in the level of skill they impart. In 2002, 25 programs in dental laboratory technology were approved (accredited) by the Commission on Dental Accreditation in conjunction with the American Dental Association (ADA). These programs provide classroom instruction in dental materials science, oral anatomy, fabrication procedures, ethics, and related subjects. In addition, each student is given supervised practical experience in a school or an associated dental laboratory. Accredited programs normally take 2 years to complete and lead to an associate degree. Graduates of 2-year training programs need additional hands-on experience to become fully qualified. Each dental laboratory owner

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[5] Department of Health Bill Analysis HB 855
[6] F.A.C. 64B27-1.001
[7] Department of Health Bill Analysis HB 855
[8] s. 466.033, F.S.
[9] 21 CFR 820 and 872
[10] Public Law 105-115
[11] Offshore outsourcing: shopping in a global market, April 2005, *Lab Management Today,* http://www.lmtcommunications.com/articles/offshoreoutsourcing.asp
[12] Source: U.S. Department of Labor, Bureau of Labor Statistics 2005. http://www.bls.gov/oco/pdf/ocos238.pdf

operates in a different way, and classroom instruction does not necessarily expose students to techniques and procedures favored by individual laboratory owners.

The National Board for Certification, an independent board established by the National Association of Dental Laboratories (NADL), offers certification in dental laboratory technology.

The overall dental health of the population has improved because of fluoridation of drinking water, which has reduced the incidence of dental cavities, and greater emphasis on preventive dental care since the early 1960s has also improve the overall dental health of the population. As a result, full dentures will be less common, as most people will need only a bridge or crown. However, during the last few years, demand has arisen from an aging public that is growing increasingly interested in cosmetic prostheses.

Job opportunities for dental laboratory technicians should be favorable, despite expected slower-than-average growth in the occupation through the year 2012. Employers have difficulty filling trainee positions, probably because entry-level salaries are relatively low and because the public is not familiar with the occupation.

The mean hourly wage in 2005 for dental laboratory technicians in Florida was $16.50. The mean annual wage or salary was $34,333. The number of dental laboratory technicians employed in Florida in 2004 was 4,454. It is projected that in 2012 there will be 5,114. This represents an annual average growth rate of 1.8 percent, slower than 1.9 percent growth rate for all occupations in Florida.[13]

Growth plus replacement needs for dental laboratory technicians in Florida are estimated to average about 177 openings per year. Of these estimated 177 openings per year, 46.9 percent of these openings are due to growth (new positions) and 53.1 percent of these openings are due to replacements. This compares with all occupations in Florida where 46.7 percent of annual openings are due to growth and 53.3 percent of annual openings are due to replacements. These figures do not take into account how many workers will be competing for these openings. The industry with the highest employment for dental laboratory technicians in Florida for 2004 was Medical Equipment and Supplies Manufacturing with 73.8 percent of the total employment. The next largest industry for this occupation was Undefined Self-Employed Workers, Primary Job with 13.1 percent of the total employment. The third largest was Industry Offices of Dentists with 8.4 percent of the total employment.[14]

Dental Laboratory Technicians Certification

The requirements for certification as a dental technician by the National Board for Certification in Dental Laboratory Technology (NBC) include either five years of experience as a dental technician or a combination of five years of experience and formal education and three examinations.[15] A person with the experience and/or educational background must take three examinations to be certified. The three examinations are taken in any order within a four-year period include: a written comprehensive, a specialty practical, and a specialty written.[16] The five specialties to choose from are:

- complete dentures
- partial dentures
- crown and bridge
- ceramics
- orthodontics

The fees for the three examinations:

- Comprehensive Written Exams: $190
- Specialty Written Exams: $190
- Practical Exam: $455

[13] Employ Florida Marketplace http://www.employflorida.com/
[14] Ibid
[15] Source: The National Board for Certification in Dental Laboratory Technology http://www.nbccert.org
[16] Ibid

There is financial assistance available to meet this cost for certain qualified individuals from the NADL.[17]

In addition, to maintain the certified dental technician designation a person must accumulate on an annual basis 12 hours of continuing education credit during the one-year renewal cycle. Those requirements include:

- One hour of documented infectious disease control or other documented Occupational Safety & Health Administration (OSHA) compliance education.
- Six hours must be documented scientific credit, which at least three hours must be NBC-Pre approved courses.
- Five hours in any of the following: documented scientific, infection control, or professional development credits, or other non-documented credit.

There are three accredited dental laboratory technology education programs in Florida where a person may pursue a two-year program of education in dental laboratory technology. The cost to complete a dental laboratory technology program ranges from $1,100 to $3,700. There is financial aide and scholarships available for students enrolled in these programs.[18] The accredited programs in dental laboratory technology include:

- Indian River Community College, Ft Pierce
- Lindsey Hopkins Technical Educational Center, Miami
- McFatter Vocational Technical School, Davie (Broward County)

According to the NADL the benefits of becoming a certified dental technician include:

- Demonstration of a significant mastery of knowledge needed in dental technology.
- Demonstration of a significant mastery of applied skills needed in dental technology.
- Demonstration of competency to peers and the public.
- Indication of being at the top of the dental technology profession.
- Establishing a basis for networking, professional recognition, friendships and life-long learning.[19]

Current law does not require that a certified dental technician be employed in a dental laboratory to operate in Florida. There are 426 certified dental laboratory technicians in this state.[20]

C. SECTION DIRECTORY:

Section 1. Amends s. 466.021, F.S.

Section 2. Amends s. 466.032, F.S.

Section 3. Provides an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

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[17] The NADL Pillar Scholarship is designed to allow qualified candidates the opportunity to sit for the three examinations that comprise the Certified Dental Technician examination process. The Pillar Scholarship covers the application and testing fees for a candidate to take the written comprehensive exam, the written specialty exam and the hands-on practical examination, one time each. It also awards the candidate a certificate that can be used to purchase study materials through NADL. http://www.nadl.org/Scholarship.shtml

[18] The Florida Dental Health Foundation in cooperation with the Florida Dental Laboratory Association and the faculty of the accredited training programs, awards scholarships to needy students enrolled in a dental laboratory technology program. Source Florida Dental Association. http://www.floridadental.org/public/careers/labtech.html. In addition, other types of financial support are available through the Department of Education. http://www.firn.edu/doe/bin00065/splist.htm

[19] NADL http://www.nbccert.org/why_cdt.shtml

[20] Department of Health Bill Analysis HB 855

1. Revenues:

   DOH could not determine the specific amount of the revenue associated with act. (See Fiscal Comments)

2. Expenditures:

   DOH could not determine the specific amount of expenditures associated with this act. (See Fiscal Comments)

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None

2. Expenditures:

   None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

If certified dental technicians command higher wages, then there is a possibility the employment of certified dental technicians as required by this act may increase the operating costs of a dentist and as a result could increase the cost to the consumer.

A one person operation would have to become a certified dental technician, hire an individual that is certified, seek employment in a laboratory that employs a certified dental technician or work in the office of a licensed dentist in order to meet the July 1, 2009 deadline for certification.

There are 426 certified dental laboratory technicians in this state and 1143 registered dental laboratories operating in the state. Even if one assumed that each of 426 certified technicians work in different dental laboratories, there would be a need for a minimum of 717 additional certified dental laboratory technicians within the next three years to comply with the requirements of this bill.[21] The need for certified technician will obviously be greater because it is unlikely that all current certified dental technicians in Florida work in different laboratories, because of the already noted favorable growth rate for the industry, and because of the predicted growth of Florida's population.[22]

The private organizations that have training programs and prepare an individual to take the certification examinations and continuing education requirements could experience an increase in demand and revenue. The National Board for Certification in Dental Laboratory Technology could experience an increase in demand for examinations and increase in revenue from examination fees and other related educational materials.

D. FISCAL COMMENTS:

According to DOH, the state may realize an increase in revenue from registration by out of state and out of country dental labs which would be required to register under this new law. There would be an expense associated with the inspection of these out of state and out of country dental laboratories.[23]

DOH also anticipates the potential for an increase in the number of complaints that would require investigation and prosecution but could not estimate the costs of these investigations and prosecutions.

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[21] This scenario excludes the effect of the bill on dental laboratories located outside the state of Florida but doing business in the state.
[22] Florida's current population of approximately 18.5 million is expected to be 19.3 million by 2009. Source: Fl Legislature Office of Economic and Demographic Research http://edr.state.fl.us/index.html
[23] Department of Health Bill Analysis HB 855

Some types of complaints may include 1) the dentist is not using a dental laboratory that is employing a certified dental technician; 2) the dentist is not using a registered dental laboratory; or 3) the dental laboratory does not have a certified dental technician.[24]

There could be an increase in enrollment in public educational facilities that provide a program of education in dental laboratory technology.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

   None

B. RULE-MAKING AUTHORITY:

Current law provides DOH rule making authority to address changes in rules to address the requirements of this act.[25]

C. DRAFTING ISSUES OR OTHER COMMENTS:

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

[24] Ibid
[25] s. 466.038, F.S.

A bill to be entitled

An act relating to dental laboratories; amending s. 466.021, F.S.; revising the services that a dentist may use for constructing orthodontic or prosthetic appliances to require that a dentist use the services of a registered dental laboratory; amending s. 466.032, F.S.; requiring that a dental laboratory employ a certified dental technician by a specified date in order to register with the Department of Health; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 466.021, Florida Statutes, is amended to read:

466.021 Employment of registered dental laboratories ~~unlicensed persons~~ by dentist; penalty.--Every duly licensed dentist who uses the services of any registered dental laboratory ~~unlicensed person~~ for the purpose of constructing, altering, repairing, or duplicating any denture, partial denture, bridge splint, or orthodontic or prosthetic appliance shall be required to furnish the registered dental laboratory ~~such unlicensed person~~ with a written work order in the ~~such~~ form ~~as~~ prescribed by rule of the board. This form shall be dated and signed by the ~~such~~ dentist, ~~and~~ shall include the patient's name or number with sufficient descriptive information to clearly identify the case for each separate and individual piece of work, and shall also include the Florida registration number of the dental laboratory performing the work. A copy of

the ~~such~~ work order shall be retained in a file in the dentist's office for a period of 4 years, and the original work order shall be retained in a file for a period of 4 years by the registered dental laboratory ~~such unlicensed person in her or his place of business~~. The ~~Such~~ file of work orders to be kept by the ~~such~~ dentist or by the registered dental laboratory ~~such unlicensed person~~ shall be open to inspection at any reasonable time by the department or its duly constituted agent. Failure of the dentist to keep records of the ~~such~~ work orders shall subject the dentist to suspension or revocation of her or his license to practice dentistry. Failure of a registered dental laboratory to have the original or electronic copy of the ~~such unlicensed person to have in her or his possession a~~ work order as required by this section is ~~shall be~~ admissible evidence of a violation of this chapter and constitutes ~~shall constitute~~ a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. This section does not preclude a registered dental laboratory from working for another registered dental laboratory if~~, provided~~ that ~~such~~ work is performed pursuant to written authorization, in a form to be prescribed by rule of the board, which evidences that the originating laboratory has obtained a valid work order and which sets forth the work to be performed. This section does not preclude a registered laboratory from providing its services to dentists licensed and practicing in another state if~~, provided~~ that ~~such~~ work is requested or otherwise authorized in written form that ~~which~~ clearly identifies the name and address of the requesting dentist and ~~which~~ sets forth the work to be performed.

Section 2. Section 466.032, Florida Statutes, is amended to read:

466.032 Registration.--

(1) Every person, firm, or corporation operating or conducting business as a dental laboratory in this state shall register biennially with the department on forms to be provided by the department and, at the same time, pay to the department a registration fee not to exceed $300 for which the department shall issue a registration certificate entitling the holder to operate a dental laboratory for a period of 2 years. Effective July 1, 2009, a dental laboratory shall employ at least one dental technician certified by the National Board for Certification in Dental Laboratory Technology during the period of its registration and shall submit the documentation with its registration.

(2) Upon the failure of any dental laboratory operator to comply with subsection (1), the department shall notify her or him by registered mail, within 1 month after the registration renewal date, return receipt requested, at her or his last known address, of the ~~such~~ failure and inform her or him of the provisions of subsections (3) and (4).

(3) Any dental laboratory operator who has not complied with subsection (1) within 3 months after the registration renewal date shall be required to pay a delinquency fee of $40 in addition to the regular registration fee.

(4) The department is authorized to commence and maintain proceedings to enjoin the operator of any dental laboratory who has not complied with this section from operating or conducting

business as a dental laboratory in this state until she or he has obtained a registration certificate and paid the required fees.

Section 3. This act shall take effect July 1, 2006.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 01 (for drafter's use only)

Bill No. **HB 855**

COUNCIL/COMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Council/Committee hearing bill: Health Care General Committee

Representative(s) Jordan offered the following:

Amendment

Remove line(s) 67 and insert:

July 1, 2011, a dental laboratory shall employ at least one

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No.02(for drafter's use only)

Bill No. **HB 855**

COUNCIL/COMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Council/Committee hearing bill: Health Care General Committee

Representative(s) Jordan offered the following:

Amendment (with title amendment)

Remove line(s) 71 and insert:

registration. This requirement does not apply to a dental laboratory that is physically located within a dental practice as operated by a licensed dentist as defined in this chapter.

========== T I T L E A M E N D M E N T ==========

Remove line(s) 9 and insert:

the Department of Health; providing an exception; providing an effective date.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 03(for drafter's use only)

Bill No. **HB 855**

COUNCIL/COMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Council/Committee hearing bill: Health Care General Committee

Representative(s) Jordan offered the following:

Amendment (with title amendment)

On line(s) 87 after the period insert:

Section 3. Section 466.036, Florida Statutes is amended to read:

466.036 Information; periodic inspections; equipment and supplies.--The department may require from the applicant for a registration certificate to operate a dental laboratory any information necessary to carry out the purpose of this chapter, including proof that the applicant has the equipment and supplies necessary to operate as determined by rule of the department, and shall require periodic inspection of all dental laboratories operating in this state. Such inspections shall include, but not be limited to, inspection of sanitary conditions, equipment, supplies, and facilities on the premises. The department shall specify dental equipment and supplies that are not permitted in a registered dental laboratory. The department shall not conduct inspection of any registered dental laboratories located in another state or country.

Amendment No. 03(for drafter's use only)

========== T I T L E A M E N D M E N T ==========

On line(s) 9 after the semicolon insert:

Amending s. 466.036, F.S., prohibiting the Department of Health from conducting inspections of registered dental laboratories located in another state or country;

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 7063 PCB GO 06-24 OGSR Alzheimer's Center and Research Institute
SPONSOR(S): Governmental Operations Committee, Rivera
TIED BILLS: **IDEN./SIM. BILLS:** SB 2066

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
Orig. Comm.: Governmental Operations Committee	6 Y, 0 N	Williamson	Williamson
1) Health Care General Committee		Ciccone	Brown-Barrios
2) State Administration Council			
3)			
4)			
5)			

SUMMARY ANALYSIS

The Open Government Sunset Review Act requires the Legislature to review each public records and each public meetings exemption five years after enactment. If the Legislature does not reenact the exemption, it automatically repeals on October 2nd of the fifth year after enactment.

The bill reenacts the public records exemption for the Johnnie B. Byrd, Sr., Alzheimer's Center and Research Institute. The exemption will repeal on October 2, 2006, if this bill does not become law.

The bill does not appear to have a fiscal impact on state or local government.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

This bill does not appear to implicate any of the House Principles.

B. EFFECT OF PROPOSED CHANGES:

Background

Florida law establishes the Johnnie B. Byrd, Sr., Alzheimer's Center and Research Institute (Alzheimer's Center) at the University of South Florida. The law requires the organization of a Florida not-for-profit corporation (corporation) for the sole purpose of governing and operating the Alzheimer's Center. Records of the corporation and its subsidiaries are public records.[1]

Current law provides a public records exemption for the Alzheimer's Center.[2] The following information is confidential and exempt[3] from public records requirements:

- Personal identifying information relating to program clients;
- Patient medical or health records;
- Materials that relate to methods of manufacture or production, potential trade secrets, potentially patentable material, actual trade secrets, or proprietary information received, generated, ascertained, or discovered during the course of research;
- Business transactions resulting from research;
- The identity of donors or prospective donors to the Alzheimer's Center who wishes to remain anonymous;
- Information received which is otherwise confidential and exempt; and
- Information received from a person from another state or nation or the Federal Government, which is confidential or exempt pursuant to those laws.

The Alzheimer's Center must provide such information to a governmental entity in the furtherance of that entity's duties and responsibilities. The governmental entity must maintain the confidential and exempt status of the information.

Pursuant to the Open Government Sunset Review Act,[4] the exemption will repeal on October 2, 2006, unless reenacted by the Legislature.

Effect of Bill

The bill removes the repeal date, thereby reenacting the public records exemption. It also makes editorial changes and removes superfluous language.

The bill removes the exemption for information received by the institute, which is otherwise confidential and exempt because it is unnecessary. In addition, it removes the clause reiterating the general

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[1] Section 1004.445, F.S.

[2] Section 1004.445(9), F.S.

[3] There is a difference between records that are exempt from public records requirements and those that are *confidential* and exempt. If the Legislature makes a record confidential and exempt, such record cannot be released by an agency to anyone other than to the persons or entities designated in the statute. *See* Attorney General Opinion 85-62. If a record is simply made exempt from disclosure requirements, an agency is not prohibited from disclosing the record in all circumstances. *See Williams v. City of Minneola*, 575 So.2d 683, 687 (Fla. 5th DCA), review denied, 589 So.2d 289 (Fla. 1991).

[4] Section 119.15, F.S.

requirement that a governmental entity granted access to confidential and exempt information must maintain the status of that information. In *Ragsdale v. State*,[5] the Florida Supreme Court held that

> [T]he applicability of a particular exemption is determined by the document being withheld, not by the identity of the agency possessing the record . . . the focus in determining whether a document has lost its status as a public record must be on the policy behind the exemption and not on the simple fact that the information has changed agency hands.[6]

In *City of Riviera Beach v. Barfield*,[7] the court stated "[h]ad the legislature intended the exemption for active criminal investigative information to evaporate upon the sharing of that information with another criminal justice agency, it would have expressly provided so in the statute."[8] As such, the provision is unnecessary and has been removed, because had the Legislature intended for the confidential and exempt status to evaporate then the Legislature would have stated as much.

C. SECTION DIRECTORY:

Section 1 amends s. 1004.445(9), F.S., to remove the October 2, 2006, repeal date.

Section 2 provides an October 1, 2006, effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   This bill does not create, modify, amend, or eliminate a state revenue source.

2. Expenditures:

   The bill may represent a minimal non-recurring positive impact on state expenditures. A bill enacting or amending a public records exemption causes a non-recurring negative fiscal impact in the year of enactment because of training employees responsible for replying to public records requests. In the case of bills reviewed under the Open Government Sunset Review process, training costs are incurred if the bill does not pass or if the exemption is amended, as retraining is required. Because the bill eliminates the repeal of the exemption, the state may recognize a minimal nonrecurring decrease in expenditures because employee-training activities are avoided.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   This bill does not create, modify, amend, or eliminate a local revenue source.

2. Expenditures:

   This bill does not create, modify, amend, or eliminate a local expenditure.

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[5] 720 So.2d 203 (Fla. 1998).
[6] *Id.* at 206, 207.
[7] 642 So. 2d 1135 (Fla. 4th DCA 1994), *review denied*, 651 So. 2d 1192 (Fla. 1995). In *Barfield*, Barfield argued that once the City of West Palm Beach shared its active criminal investigative information with the City of Riviera Beach the public records exemption for such information was waived. Barfield based that argument on a statement from the 1993 *Government-In-The-Sunshine Manual* (a booklet prepared by the Office of the Attorney General). The Attorney General opined "once a record is transferred from one public agency to another, the record loses its exempt status." The court declined to accept the Attorney General's view. As a result, that statement has been removed from the *Government-In-The-Sunshine Manual*.
[8] *Id.* at 1137.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

The bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds. The bill does not reduce the percentage of a state tax shared with counties or municipalities. The bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Open Government Sunset Review Act

The Open Government Sunset Review Act sets forth a legislative review process for newly created or substantially amended public records or public meetings exemptions. It requires an automatic repeal of the exemption on October 2nd of the fifth year after creation or substantial amendment, unless the Legislature reenacts the exemption.

The Act provides that a public records or public meetings exemption may be created or maintained only if it serves an identifiable public purpose, and may be no broader than is necessary to meet one of the following purposes:

- Allowing the state or its political subdivisions to effectively and efficiently administer a governmental program, which administration would be significantly impaired without the exemption;
- Protecting sensitive personal information that, if released, would be defamatory or would jeopardize an individual's safety. However, only the identity of an individual may be exempted under this provision; or,
- Protecting trade or business secrets.

If, and only if, in reenacting an exemption that will repeal, the exemption is expanded (essentially creating a new exemption), then a public necessity statement and a two-thirds vote for passage are required because of the requirements of Art. 1, s. 24(c), Florida Constitution. If the exemption is reenacted with grammatical or stylistic changes that do not expand the exemption, if the exemption is narrowed, or if an exception to the exemption is created (e.g., allowing another agency access to the confidential or exempt records), then a public necessity statement and a two-thirds vote for passage are not required.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

None.

A bill to be entitled

An act relating to a review under the Open Government Sunset Review Act regarding the Johnnie B. Byrd, Sr., Alzheimer's Center and Research Institute; amending s. 1004.445, F.S., which provides an exemption from public records requirements for personal identifying information relating to clients of programs created or funded through the Johnnie B. Byrd, Sr., Alzheimer's Center and Research Institute and held by the institute, the University of South Florida, or the State Board of Education, medical or health records relating to patients held by the institute, materials that relate to methods of manufacture or production, potential trade secrets, potentially patentable material, actual trade secrets, or proprietary information received, generated, ascertained, or discovered during the course of research conducted by or through the institute and business transactions resulting from such research, personal identifying information of a donor or prospective donor to the institute who wishes to remain anonymous, and any information received by the institute from a person from another state or nation or the Federal Government that is otherwise confidential or exempt pursuant to the laws of that state or nation or pursuant to federal law; narrowing the exemption; making editorial changes; removing superfluous language; removing the scheduled repeal of the exemption; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (9) of section 1004.445, Florida Statutes, is amended to read:

1004.445 Johnnie B. Byrd, Sr., Alzheimer's Center and Research Institute.--

(9) The following information is confidential and exempt from ~~the provisions of~~ s. 119.07(1) and s. 24, Art. I of the State Constitution:

(a) Personal identifying information relating to clients of programs created or funded through the Johnnie B. Byrd, Sr., Alzheimer's Center and Research Institute that ~~which~~ is held by the institute, the University of South Florida, or the State Board of Education ~~or by persons who provide services to clients of programs created or funded through contracts with the Johnnie B. Byrd, Sr., Alzheimer's Center and Research Institute~~;

(b) ~~Any~~ Medical or health records relating to patients held ~~which may be created or received~~ by the institute;

(c) Materials that relate to methods of manufacture or production, potential trade secrets, potentially patentable material, actual trade secrets as defined in s. 688.002, or proprietary information received, generated, ascertained, or discovered during the course of research conducted by or through the institute and business transactions resulting from such research;

(d) The personal identifying information ~~identity~~ of a donor or prospective donor to the ~~Johnnie B. Byrd, Sr., Alzheimer's Center and Research~~ institute who wishes to remain

anonymous~~, and all information identifying such donor or prospective donor~~; and

(e) ~~Any information received by the institute in the performance of its duties and responsibilities which is otherwise confidential and exempt by law; and~~

~~(f)~~ Any information received by the institute from a person from another state or nation or the Federal Government that ~~which~~ is otherwise confidential or exempt pursuant to the laws of that state ~~state's~~ or nation ~~nation's laws~~ or pursuant to federal law.

Any governmental entity that demonstrates a need to access such confidential and exempt information in order to perform its duties and responsibilities shall have access to such information ~~and shall otherwise keep such information confidential and exempt. This section is subject to the Open Government Sunset Review Act of 1995 in accordance with s. 119.15 and shall stand repealed on October 2, 2006, unless reviewed and saved from repeal through reenactment by the Legislature~~.

Section 2. This act shall take effect October 1, 2006.

Health Care General Committee

Wednesday, March 22, 2006
9:00 AM – 12:00 PM
306 HOB

COMMITTEE MEETING PACKET

Revised

ADDENDUM "A" (03/21/2006; 9:00 PM)

Allan G. Bense
Speaker

Gayle B. Harrell
Chair

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 01 (for drafter's use only)

Bill No. **HB 645**

COUNCIL/COMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Council/Committee hearing bill: Health Care General

Representative(s) Gelber offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Section 400.0627, Florida Statutes, is created to read:

400.0627 Emergency electric power system capacity.--

(1) It is the intent of the Legislature that each nursing home facility in this state be encouraged to have an emergency electrical power system capacity that is sufficient to remain fully operational during and after an emergency in order to maintain the safety and health of the residents of the nursing home facility and, if necessary, to provide care to residents evacuated from other nursing home facilities.

(2) By July 1, 2006, the Agency for Health Care Administration shall commence implementation of a 2-year pilot program to provide the capability for increasing the capacity of emergency electrical power systems of nursing home facilities. To participate in the pilot program a nursing home facility must:

(a) Be located in Broward County, Collier County, Dade County, Monroe County, or Palm Beach County;

(b) Not be located within a hurricane-evacuation zone;

(c) Not have been cited for a class I deficiency within the 30 months preceding the commencement date of implementation of the pilot program;

(d) Be capable of accepting and agree to accept at least 30 residents who are transferred from other nursing home facilities pursuant to applicable life safety and firesafety laws as determined by the agency. During any such evacuation, the facility from which the residents are transferred shall provide the receiving facility with the staff required to care for the transferred residents; and

(e) Have a contract with a company that is able to supply an electrical generator when needed.

(3)(a) A nursing home facility must notify the Agency for Health Care Administration if it seeks to participate in the pilot program. If a facility providing such a notice meets the criteria in subsection (2) and funds are available as specified in paragraph (3)(b), the agency shall reimburse the facility for one-half the cost up to $15,000, of the contract described in paragraph (2)(e) to secure an electrical generator within the 2-year duration of the pilot program. The agency shall also reimburse the facility for the cost incurred to install a permanent, predesigned electrical service entry that will allow a quick connection to a temporary electrical generator. The connection must be installed inside a permanent metal enclosure that is rated as suitable for the purpose of providing such an entry, may be located on the exterior of the building, and must be adequate to allow the operation of the facility under normal conditions. Before any such reimbursement, the facility must

provide the agency with documentation that the installation is complete and the electrical work associated with the installation was performed by a certified electrical contractor.

(b) Reimbursement to a facility under paragraph (a) is available to the extent that funds are appropriated for each of the 2 years of the pilot program. Funds shall be provided to eligible facilities on a first-come, first-served basis.

(4) A nursing home facility that participates and is reimbursed for an installation under the pilot program shall ensure the proper safekeeping and maintenance of the installation and allow the Agency for Health Care Administration access as needed to inspect the installation.

(5) This section does not require a nursing home facility to participate in the pilot program or to modify the capacity of its existing emergency electrical power system. However, if the existing emergency electrical power system of a nursing home facility is modified as part of an installation for which reimbursement is provided under subsection (3), such system must comply with all current codes and standards.

(6) The Agency for Health Care Administration may adopt rules to administer this section.

Section 2. This act shall take effect upon becoming a law.

========== T I T L E A M E N D M E N T ==========

Remove the entire title and insert:

A bill to be entitled

An act relating to nursing home facilities; creating s. 400.0627, F.S.; providing legislative intent; requiring the Agency for Health Care Administration to commence a pilot program to increase the emergency electrical power capacity of nursing home facilities by reimbursing such

facilities for the costs of installing a permanent connection for a generator and of a contract for the acquisition of a generator when needed; providing eligibility criteria for reimbursement; authorizing the agency to adopt rules; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 699 CS Health Care
SPONSOR(S): Negron and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1216

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee	7 Y, 4 N, w/CS	Bell	Mitchell
2) Health Care General Committee		Ciccone	Brown-Barrios
3) Health & Families Council			
4)			
5)			

SUMMARY ANALYSIS

HB 699 w/CS amends ss. 458.331 and 459.015, F.S., to give the Allopathic (MD) and Osteopathic (DO) Medical Boards increased oversight of standards involving the supervision of licensed health care practitioners.

The bill allows the Medical Boards to develop rules related to standards of practice and standards of care for supervision of physician assistants, paramedics, emergency medical technicians, advanced registered nurse practitioners, anesthesiologist assistants, and persons performing electrolysis or laser electrology who are not under direct on-site supervision of the supervising physician. The Medical Boards may vary the rules based on specialty of the physician, type of licensed health care practitioner under supervision, and the practice setting.

The rules may include:

- The percentage of time the supervising physician spends directly supervising the licensed health care practitioners;
- Standards for adequate supervision, including the standards for review of medical records and the allowable distance of the licensed health care practitioners from the supervising physician; and
- The number of each type of licensed health care practitioner which a supervising physician may supervise.

There is no fiscal impact associated with this bill.

The effective date of the bill is upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government – The bill expands regulatory control by the Board of Medicine. It provides that the Board of Medicine may establish by rule standards of practice and standards of care, including delegation to other personnel, for particular practice settings. The rules may include: time of direct supervision, standards for adequate supervision, distance limitations, and the number of practitioners that physicians can supervise.

B. EFFECT OF PROPOSED CHANGES:

HB 699 w/CS amends ss. 458.331 and 459.015, F.S., to give the Allopathic (MD) and Osteopathic (DO) Medical Boards more oversight of standards involving the supervision of licensed health care practitioners.

The bill allows the Medical Boards to craft rules related to standards of practice and standards of care for supervision of several professions when they are not under direct on-sight supervision of the supervising physician. The professions affected by the bill are: physician assistants, paramedics, emergency medical technicians, advanced registered nurse practitioners, anesthesiologist assistants, and persons performing electrolysis or electrology using laser or light-based hair removal. The Medical Boards may vary the rules based on physician specialty, type of licensed health care practitioner under supervision, and the practice setting.

The rules may include:

- The percentage of time the supervising physician spends directly supervising the licensed health care practitioners;
- Standards for adequate supervision, including the standards for review of medical records and the allowable distance of the licensed health care practitioners from the supervising physician; and
- The number of each type of licensed health care practitioner which a supervising physician may supervise.

The bill specifies that any rule promulgated must apply equally to physician assistants (PAs) and advanced registered nurse practitioners (ARNPs).

The bill provides that rules developed by the Medical Boards may take precedence over all other statutorily defined health care practitioner supervision provisions in chapters 458 and 459, F.S.

The full impact of the bill is indeterminate because the bill gives the Board of Medicine the authority to promulgate rules in a wide variety of situations. As a result, it is difficult to ascertain potential impacts these rules may have on the health professions referenced in the bill.

The bill lists a number of exemptions to rules promulgated by the Boards of Medicine. The following facilities and health care practitioners are exempt:

- Health care practitioners working in a facility licensed under ch. 395, F.S., which include hospitals, ambulatory surgical centers, and mobile surgical facilities;
- Health care practitioners providing services in conjunction with a college of medicine;
- Health care practitioners providing services in a nursing home licensed under part II of ch. 400, F.S.;
- Assisted living facility licensed under part III of ch. 400, F.S.;

- Retirement community consisting of independent living units and either a licensed nursing home or assisted living facility; and
- Rural health network under s. 381.0406, F.S.

PRESENT SITUATION

Overview - the Use of Physician Extenders

ARNPs and physician assistants (PAs) are commonly referred to as "physician extenders" because they extend the ability of a physician to treat, indirectly, more patients. Physician extenders such as nurse practitioners and nurse anesthetists have become prominent health providers. Although they generally work alongside doctors, these physician extenders administer frontline medical care to patients with increasing needs for preventative care or monitoring for people with disabilities, or diseases such as diabetes or congestive heart failure. Physician extenders are more willing to go to rural or inner-city areas, to work beyond traditional office hours[1], and are able to spend additional time with patients on visits.[2] ARNPs and PAs have also taken on increased responsibility in caring for seniors, especially those in nursing homes, due to a severe and growing shortage of geriatricians in the United States.[3] Rising costs of healthcare have further increased the demand for nonphysician providers, who are able to care for patients at the same or lower cost than physicians and whose services are often covered on state and private health plans.[4] Research has shown that many nonphysician providers perform at least as safely as physicians do in these expanded roles[5]; however concerns remain that nonphysicians remain carefully supervised and trained in their scope of practice.[6]

History - Ortiz v. Department of Health, Board of Medicine, 2004[7]

Recently, there has been a court challenge that relates to the Board of Medicine promulgating rules regarding physician extenders. Specifically, the Board of Medicine promulgated administrative Rule 64B8-9.009(6)(b)1.a., F.A.C., to require a surgeon in an out-patient facility to have a licensed MD or DO anesthesiologist present to supervise the administration of anesthesia by Certified Registered Nurse Anesthetists (CRNAs). Many CRNAs objected to this rule because they felt it was not fiscally prudent for a surgeon's office to employ a physician anesthesiologist to supervise and a CRNA to perform the procedure. The Board of Medicine rule prompted a court challenge in Ortiz v. Department of Health, Board of Medicine, 2004.[8]

The court found that the Board of Medicine's rule requiring a surgeon in an out-patient facility to have a licensed anesthesiologist present to supervise the administration of anesthesia for Level III surgery, was an invalid exercise of delegated authority.

As part of the ruling, the court specifically cited s. 458.303, F.S., as limiting the reach of s. 458.331, F.S. Pursuant to s. 458.303(2), F.S., the grant of rulemaking under s. 458.309, F.S., and s. 458.331, F.S., cannot be, "construed to prohibit any service rendered by a registered nurse or a licensed practical nurse, if such service is rendered under the direct supervision and control of a licensed nurse,

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[1] Gearon, C.J. "Medicine's Turf Wars." *US News & World Report.* January 31, 2005. Available online at www.usnews.com/usnews.issue/050131/health/31turf.htm.

[2] "Extend your practice—not your liability." *Medical Economics*. February 18, 2005.

[3] Oliff, L. "Beyond Asking Your Doctor." *Pharmaceutical Executive* 24 no2 102, 104 F 2004.

[4] Hooker, S.H., and McCaig, L.F. "Use of physician assistants and nurse practitioners in primary care, 1995-1999." *Health Affairs*. July/August 2001.

[5] According to Linda Aiken, director of the University of Pennsylvania's Center for Health Outcomes and Policy Research, over 100 studies have examined the care delivered by nurse practitioners and none demonstrated a negative impact of their care on health. Quoted in "Medicine's Turf Wars." *US News & World Report.* January 31, 2005. Available online at www.usnews.com/usnews.issue/050131/health/31turf.htm.

[6] Robert Wise, vice president for standards and survey methods at the Joint Commission on Accreditation of Healthcare Organizations, quoted in Gearon, C.J. "Medicine's Turf Wars." *US News & World Report.* January 31, 2005. Available online at www.usnews.com/usnews.issue/050131/health/31turf.htm.

[7] See *Ortiz*.

[8] See *Ortiz*.

if such service is rendered under the direct supervision and control of a licensed physician who provides specific direction for any service to be performed and gives final approval to all services performed."

Thus, the court found that under ss. 458.303(2) and 458.331, F.S., as long as a licensed physician has direct supervision and control over the registered nurse, the fact that services are provided by that nurse cannot be a ground for discipline of the physician, and no rules can prohibit such services by a registered nurse.

The Board claimed that its rule did not control the actions of CRNAs, but the court found that the rule indirectly limited the practice of CRNAs. Instead of simply prohibiting CRNAs from administering anesthesia under supervision of the surgeon, the Board provided grounds for disciplining the surgeon if he or she supervises the CRNA. Either way, currently, s. 458.303(2), F.S., prevents the use of rulemaking authority for this purpose.

The Ortiz decision noted that both parties agreed that patient safety was not an issue in the proceedings.

SUPERVISION STANDARDS

The health care professionals referenced in the bill are all regulated differently by statute and rule and have varied supervisory relationships with physicians.

Supervision Standards for Advanced Registered Nurse Practitioners

Nurses are regulated in their own practice act. Nurses are licensed and regulated by the Board of Nursing pursuant to part I of chapter 464, F.S. There are approximately 9,500 Advanced Registered Nurse Practitioners (ARNPs) in Florida.

ARNPs practice under a protocol with a supervising physician and are not required to be under direct supervision. There is no limit on the number of ARNPs that a physician may supervise at any one time. ARNPs may practice in locations without the supervising physician on premises.[9] A 2005 Florida Board of Nursing study determined that 90% of nursing protocols have one physician supervising one or two ARNPS. The study also concluded that less that 2% of nurse protocols have one physician supervising four or more ARNPs. Almost all, 99%, of the ARNPs and supervising physicians are located within the same metropolitan area (roughly a 50-mile radius of an urban center).[10]

ARNPs perform medical acts of diagnosis, treatment, and operation pursuant to a protocol between the ARNP and a Florida-licensed medical doctor, osteopathic physician, or dentist. The degree and method of supervision is determined by the ARNP and the supervisor, must be appropriate for prudent health care providers under similar circumstances, and must be specifically identified in a written protocol. Unless these rules set a different level of supervision for a particular act, general supervision is required.[11] The number of ARNPs to be supervised must be limited to insure that an acceptable standard of medical care is rendered in consideration of: risk to patient, educational preparation, specialty, and experience of parties to the protocol, complexity and risk of the procedures, practice setting, and availability of the supervisor.

Supervision Standards for Anesthesiologist Assistants (a form of specialty nursing)

Anesthesiologist Assistants or Certified Registered Nurse Anesthesiologists (CRNAs) are a specialized form of Advanced Registered Nurse Practitioner that requires a masters degree. CRNAs are licensed under part I of the Nurse Practice Act, chapter 464, F.S. Every CRNA must enter into a supervisory relationship with a physician or dentist; and must file a written protocol describing the relationship based on criteria set forth in chapters 458, 459, and 466, F.S. The supervising physician must only delegate tasks and procedures to the CRNA which are within the supervising physician's scope of

[9] Rule 64B8-35, Florida Administrative Code.
[10] Florida Board of Nursing, Study of ARNP Protocols, November 1, 2005.
[11] The written protocol signed by all parties represents the mutual agreement of the supervising physician and the ARNP and must include information defined by Rule 64B9-4, Florida Administrative Code, and s. 458.348(2), F.S.

practice, and the CRNAs can work in any setting that is within the scope of practice of the supervisor's practice. CRNAs personally administer 65% of all anesthetics given to patients each year in the United States.[12]

Under facility licensure requirements of s. 395.0191, F.S., CRNAs working in ambulatory surgery centers or hospitals must be supervised by a physician or a dentist.

Supervision Standards for Paramedics & Emergency Medical Technicians

Paramedics and emergency medical technicians are regulated under ch. 401, F.S., Medical Transportation and Services. They are also referenced in s. 458.348, F.S. There are approximately 18,000 paramedics and 28,000 emergency medical technicians (EMTs) in Florida. Each paramedic and EMT employed within an Emergency Medical Services (EMS) system must operate under the direct supervision of a physician medical director, or indirectly by standing orders and/or protocols.[13] Each EMS agency employs or contracts with a physician medical director to provide this medical oversight and quality assurance. The larger EMS providers in Florida have over 1,000 EMTs and paramedics on staff, all of them working under one medical director.

Medical directors must supervise and assume direct responsibility for the medical performance of the EMTs and paramedics, and must perform duties including advising, consulting, training, counseling, and overseeing of services. This includes appropriate quality assurance but does not include administrative or managerial functions. Each medical director is required to establish a quality assurance committee to provide reviews of all EMTs and paramedics operating under the director's supervision.[14]

The Emergency Medical Services Advisory Council was created for the purpose of acting as the advisory body to the EMS program. The Council's role includes:

- Identify and make recommendations to the Department of Health (DOH) concerning the appropriateness of suggested changes to statute and administrative rules; and
- To provide technical support to DOH in the areas of EMS and trauma systems design, technology, drugs and dosages, medical protocols, training requirements, and other aspects of procedure.[15]

The Division of Emergency Medical Operations has noted that limiting the number of allied health practitioners that can practice under the authority of a single physician could significantly impact the daily operations of an EMS service. According to the Division, while the implementation of the bill alone would not directly impact the EMS community, the rule language required by the bill may have a tremendous impact on the way EMS is designed and operated statewide.

Supervision Standards for Physician Assistants

Physician assistants (PAs) are regulated under ss. 458.347 and 459.022, F.S. There are approximately 3,000 licensed PAs in Florida. PAs may practice under the direct or indirect supervision of an MD or DO. A physician may supervise up to four PAs at any one time and the supervising physician must be

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[12] American Association of Nurse Anesthetists, 2006.
[13] Chapter 64E-2, Florida Administrative Code.
[14] Section 401.265, F.S
[15] Section 401.245, F.S. The council has up to 15 members, and representatives include physicians, EMS administrators, paramedics, EMTs, emergency nurse, hospital administrators, air ambulance service representatives, educators, and laypersons who are in no way connected with emergency medical services and one of whom is a representative of the elderly. Ex officio members of the advisory council from state agencies include, but are not limited to, representatives from the Department of Education, the Department of Management Services, the State Fire Marshal, the Department of Highway Safety and Motor Vehicles, the Department of Transportation, and the Department of Community Affairs.

qualified in the medical treatment areas delegated to a PA.[16] The "primary supervising physician" assumes responsibility and legal liability for the services rendered by the PAs at all times. "Direct supervision" entails the physical presence of the supervising physician on the premises so that he or she is immediately available to the PA when needed. "Indirect supervision" requires reasonable proximity between the supervising physician and the PA and requires the ability to communicate by telecommunications.[17]

There is a Council on Physician Assistants that reports to the Board of Medicine. The Council's duties include:

- Recommendation of the licensure of PAs to the Department of Health (DOH); and
- Development of rules regulating the use of PAs by physicians (proposed rules submitted by the council must be approved by both medical and osteopathic boards).

The council is comprised of five members including three physicians appointed by the chairperson of the Board of Medicine, one physician appointed by the chairperson of the Board of Osteopathic Medicine, and a PA appointed by the secretary of the department or his or her designee. At least two of the members appointed to the council must be physicians who supervise PAs in their practice.[18]

Disciplinary Procedures

Disciplinary procedures for health professions vary in practice and procedures. Nurses (ARNPs and CRNAs) are disciplined directly under Chapter 464, F.S., the Nurse Practice Act. Emergency personnel and PAs are disciplined by a mixed-member council. Health professions have at least one peer that is included in disciplinary and regulatory proceedings.

Disciplinary Actions for Nursing

Currently RNs and LPNs may be directly disciplined under s. 464.018, F.S. One of the disciplinary criteria is, "failing to meet minimal standards of acceptable and prevailing nursing practice, including engaging in acts for which the licensee is not qualified by training or experience." Nurses can also be disciplined for violating any of the Nurse Practice Act (chapter 464, F.S.), the Health Professions and Occupations: General Provisions (chapter 456, F.S.), or rules adopted by the Board of Nursing.

Disciplinary Actions for Doctors

Section 458.331(1) (v), F.S., provides ground for discipline of MDs who practice beyond the scope permitted by law or perform any procedure that the MD is not competent to perform. This section also provides that the Board of Medicine may establish rules for standards of practice and standards of care for particular practice settings including delegating to other professions.

Joint Committee of the Boards of Nursing and Medicine

In s. 464.003, F.S, the Legislature created a joint committee of the Boards of Nursing and Medicine to develop rules concerning protocols and supervision of ARNPs and other advanced specialty nurses. According to the Department of Health, HB 699 w/CS makes possible rulemaking by the Board of Medicine which may restrict the practice of nursing through threatened discipline of physicians who supervise nurses. DOH asserts that this rulemaking authority may take some rulemaking authority from the Joint Committee of the Board of Nursing and Medicine.

BACKGROUND

Scope of Practice Authority

Each year, the Florida Legislature hears bills and amendments to change the scope of practice and standards of existing professions. The legal authority to provide and be reimbursed for health care

[16] Sections 458.347 and 459.022, F.S.
[17] Rules for Medical Practice, Chapter 64B8-30, Florida Administrative Code; Rules for Osteopathic Medicine, Chapter 64B15-6, Florida Administrative Code.
[18] Sections 458.347 and 459.022, F.S.

services is tied to state statutes generally referred to as *practice acts. Practice acts* establish professional "scopes of practice," and often differ from state to state. Legislative debate generally revolves around whether new or unregulated disciplines and occupations should be regulated and whether professions should be granted expanded practice authority.

Specialized Nursing Practice

Specialization in nursing dates from the early part of the twentieth century. Many specialty nursing programs require a master's degree and require additional state certification and licensure. Some of the primary nurse specialties are[19]:

- Critical Care;
- Nurse Anesthetists;
- Nurse Midwives;
- Public Health Nursing; and
- Nursing Education.

There have been some concerns raised that HB 699 w/CS may limit the practice of specialty nursing if a nurse is working under a physician that does not share their specialty.

C. SECTION DIRECTORY:

Section 1. Amends s. 458.331, F.S., to direct the Board of Medicine to promulgate rules regarding the standards of practice and standards of care for physicians who supervise licensed health care practitioners who are not under direct, onsite supervision and provides exemptions.

Section 2. Amends s. 459.051, F.S., to direct the Board of Osteopathic Medicine to promulgate rules regarding the standards of practice and standards of care for physicians who supervise licensed health care practitioners who are not under direct, onsite supervision and provides exemptions.

Section 3. Provides that the bill shall take effect upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

[19] Nursing Health Care. 1992 May; 13(5):254-9

The direct economic impact on the private sector is indeterminate because the bill allows the Board of Medicine to develop rules regarding supervision standards of health professionals. The impact cannot be determined until the Board of Medicine promulgates the rules.

D. FISCAL COMMENTS:

HB 699 w/CS may result in an increase in health care costs in certain markets. The bill allows the Board of Medicine to promulgate stronger physician supervision rules. When promulgated, the rules may decrease the financial advantage of hiring a nurse or physician assistant to perform certain tasks and result in more direct physician care. Patient care received from a nurse or physician assistant is usually less expensive than care received by a physician.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

Refer to Rule-Making Authority.

B. RULE-MAKING AUTHORITY:

Rule-making authority granted in the bill appears unclear because it may leave significant discretion to the Board of Medicine, potentially raising a constitutional concern as to unlawful delegation of legislative authority due to lack of adequate guidelines.[20]

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On March 8, 2006 the Health Care Regulation Committee adopted five amendments and reported the bill favorably.

Amendment 1: Inserted a list of facilities and practitioners who are exempt from the rules promulgated as a result of the bill.
Amendment 2 & 3: Specified that rural health networks are exempt from the rules promulgated as a result of the bill.
Amendment 4 & 5: Specified that the rules promulgated as a result of the bill would apply equally to physician assistants and advanced registered nurse practitioners.

The analysis is drafted to the committee substitute.

[20] *See, e.g., Avatar Development Corporation v. State, 723 So.2nd 199 (Fla. 1998)*

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 01 (for drafter's use only)

Bill No. **HB 699 CS**

COUNCIL/COMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Council/Committee hearing bill: Health Care General Committee

Representative(s) Negron offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. A new subsection (4) is added to section 458.348, Florida Statutes, to read:

(4) Supervisory Relationships in Medical Office Settings. A physician who supervises an Advanced Registered Nurse Practitioner or Physician Assistant at a medical office other than the physician's primary practice location, where the Advanced Registered Nurse Practitioner or Physician Assistant is not under the onsite supervision of a supervising physician, must comply with the standards set forth below. For the purpose of this subsection, a physician's "primary practice location" means the address reflected on the physician's profile published pursuant to s. 456.041.

(a) A physician who is engaged in providing primary health care services shall not supervise more than four (4) offices in addition to the physician's primary practice location. For the purpose of this subsection, "primary health care" means health care services that are commonly provided to patients without

referral from another practitioner and excludes practices providing primarily dermatologic and skin care services (which include aesthetic skin care services).

(b) A physician who is engaged in providing specialty health care services shall not supervise more than two (2) offices in addition to the physician's primary practice location. For the purpose of this subsection, "specialty health care" means health care services that are commonly provided to patients with a referral from another practitioner and excludes practices providing primarily dermatologic and skin care services (which include aesthetic skin care services).

(c) a physician who supervises an Advanced Registered Nurse Practitioner or Physician Assistant at a medical office other than the physician's primary practice location, where the Advanced Registered Nurse Practitioner or Physician Assistant is not under the onsite supervision of a supervising physician and the services offered at the office are primarily dermatologic or skin care services (which include aesthetic skin care services) other than plastic surgery, must comply with the standards listed in subparagraphs (i)-(iv). Notwithstanding the provisions of s. 458.347(4)(e)8 or any administrative rule, a physician supervising a Physician Assistant shall not be required to review and co-sign charts or medical records prepared by such Physician Assistant. For the purpose of this subsection, a physician's "primary practice location" means the address reflected on the physician's profile published pursuant to s. 456.041.

(i) the physician shall submit to the Board of Medicine the addresses of all offices where he is supervising an Advanced Registered Nurse Practitioner or a Physician's Assistant that are not the physician's primary practice location.

(ii) the physician must be either board certified or board eligible in dermatology or plastic surgery as recognized by the Board of Medicine pursuant to Section 458.3312, Florida Statutes.

(iii) All such offices that are not the physician's primary place of practice must be within 25 miles of the physician's primary place of practice or in a county that is contiguous to the county of the physician's primary place of practice. However, the distance between any of the offices shall not exceed 75 miles.

(iv) the physician may only supervise one office other than the physician's primary place of practice except that until July 1, 2011 the physician may supervise up to two medical offices other than the physician's primary place of practice if the addresses of the offices are submitted to the Board of Medicine prior to July 1, 2006. Effective July 1, 2011 the physician may supervise only one office other than the physician's primary place of practice regardless of when the addresses of the offices were submitted to the Board of Medicine.

(d) A physician who supervises an office in addition to the physician's primary practice location shall conspicuously post in each of the physician's offices a current schedule of the regular hours that the physician is present in that office, and the hours that the office is open when the physician is not present.

(e) The provisions of this subsection shall not apply to health care services provided in facilities licensed under chapter 395 or in conjunction with a college of medicine or college of nursing or an accredited graduate medical or nursing education program; or to health care services provided in a nursing home licensed under part II of chapter 400, an assisted

living facility licensed under part III of chapter 400, a continuing care facility licensed under chapter 651, or a retirement community consisting of independent living units and either a licensed nursing home or assisted living facility; or to anesthesia services provided in accordance with law; or to health care services provided in a designated rural health clinic; or to health care services provided to persons enrolled in a program designed to maintain elders and persons with disabilities in a home and community-based setting; or to health care services provided in federal or state facilities.

(5) Upon initial referral of a patient by another practitioner, the physician receiving the referral must ensure that the patient is informed of the type of license held by the physician and the type of license held by any other practitioner who will be providing services to the patient. When scheduling the initial examination or consultation following such referral, the patient may decide to see the physician or any other licensed practitioner supervised by the physician, and prior to the initial examination or consultation shall sign a form indicating the patient's choice of practitioner. The supervising physician must review the medical record of the initial examination or consultation, and ensure that a written report on the initial examination or consultation is furnished to the referring practitioner within ten business days following the completion of the initial examination or consultation.

Section 2. A new section is added to Chapter 459, Florida Statutes, to read:

459.024 Formal supervisory relationships, standing orders, and established protocols; notice; standard.

(1) Notices.--

(a) When a physician enters into a formal supervisory relationship or standing orders with an emergency medical technician or paramedic licensed pursuant to s. 401.27, which relationship or orders contemplate the performance of medical acts, or when a physician enters into an established protocol with an advanced registered nurse practitioner, which protocol contemplates the performance of medical acts identified and approved by the joint committee pursuant to s. 464.003(3)(c) or acts set forth in s. 464.012(3) and (4), the physician shall submit notice to the board. The notice shall contain a statement in substantially the following form:

I, (name and professional license number of physician) , of (address of physician) have hereby entered into a formal supervisory relationship, standing orders, or an established protocol with (number of persons) emergency medical technician(s), (number of persons) paramedic(s), or (number of persons) advanced registered nurse practitioner(s).

(b) Notice shall be filed within 30 days of entering into the relationship, orders, or protocol. Notice also shall be provided within 30 days after the physician has terminated any such relationship, orders, or protocol.

(2) Protocols requiring direct supervision.--All protocols relating to electrolysis or electrology using laser or light-based hair removal or reduction by persons other than physicians licensed under this chapter or chapter 458 shall require the person performing such service to be appropriately trained and work only under the direct supervision and responsibility of a physician licensed under this chapter or chapter 458.

(3) Supervisory Relationships in Medical Office Settings. A physician who supervises an Advanced Registered Nurse Practitioner or Physician Assistant at a medical office other

than the physician's primary practice location, where the Advanced Registered Nurse Practitioner or Physician Assistant is not under the onsite supervision of a supervising physician, must comply with the standards set forth below. For the purpose of this subsection, a physician's "primary practice location" means the address reflected on the physician's profile published pursuant to s. 456.041.

(a) A physician who is engaged in providing primary health care services shall not supervise more than four (4) offices in addition to the physician's primary practice location. For the purpose of this subsection, "primary health care" means health care services that are commonly provided to patients without referral from another practitioner and excludes practices providing primarily dermatologic and skin care services (which include aesthetic skin care services).

(b) A physician who is engaged in providing specialty health care services shall not supervise more than two (2) offices in addition to the physician's primary practice location. For the purpose of this subsection, "specialty health care" means health care services that are commonly provided to patients with a referral from another practitioner and excludes practices providing primarily dermatologic and skin care services (which include aesthetic skin care services).

(c) a physician who supervises an Advanced Registered Nurse Practitioner or Physician Assistant at a medical office other than the physician's primary practice location, where the Advanced Registered Nurse Practitioner or Physician Assistant is not under the onsite supervision of a supervising physician and the services offered at the office are primarily dermatologic or skin care services (which include aesthetic skin care services) other than plastic surgery, must comply with the standards

listed in subparagraphs (i)-(iv). Notwithstanding the provisions of s. 458.347(4)(e)8 or any administrative rule, a physician supervising a Physician Assistant shall not be required to review and co-sign charts or medical records prepared by such Physician Assistant. For the purpose of this subsection, a physician's "primary practice location" means the address reflected on the physician's profile published pursuant to s. 456.041.

(i) the physician shall submit to the Board of Osteopathic Medicine the addresses of all offices where he is supervising or has a protocol with an Advanced Registered Nurse Practitioner or a Physician's Assistant that are not the physician's primary practice location.

(ii) the physician must be either board certified or board eligible in dermatology or plastic surgery as recognized by the Board of Osteopathic Medicine pursuant to Section 459.0152, Florida Statutes.

(iii) All such offices that are not the physician's primary place of practice must be within 25 miles of the physician's primary place of practice or in a county that is contiguous to the county of the physician's primary place of practice. However, the distance between any of the offices shall not exceed 75 miles.

(iv) the physician may only supervise one office other than the physician's primary place of practice except that until July 1, 2011 the physician may supervise up to two medical offices other than the physician's primary place of practice if the addresses of the offices are submitted to the Board of Osteopathic Medicine prior to July 1, 2006. Effective July 1, 2011 the physician may supervise only one office other than the physician's primary place of practice regardless of when the

addresses of the offices were submitted to the Board of Osteopathic Medicine.

(d) A physician who supervises an office in addition to the physician's primary practice location shall conspicuously post in each of the physician's offices a current schedule of the regular hours that the physician is present in that office, and the hours that the office is open when the physician is not present.

(e) The provisions of this subsection shall not apply to health care services provided in facilities licensed under chapter 395 or in conjunction with a college of medicine or college of nursing or an accredited graduate medical or nursing education program; or to health care services provided in a nursing home licensed under part II of chapter 400, an assisted living facility licensed under part III of chapter 400, a continuing care facility licensed under chapter 651, or a retirement community consisting of independent living units and either a licensed nursing home or assisted living facility; or to anesthesia services provided in accordance with law; or to health care services provided in a designated rural health clinic; or to health care services provided to persons enrolled in a program designed to maintain elders and persons with disabilities in a home and community-based setting; or to health care services provided in federal or state facilities.

(4) Upon initial referral of a patient by another practitioner, the physician receiving the referral must ensure that the patient is informed of the type of license held by the physician and the type of license held by any other practitioner who will be providing services to the patient. When scheduling the initial examination or consultation following such referral, the patient may decide to see the physician or any other

licensed practitioner supervised by the physician, and prior to the initial examination or consultation shall sign a form indicating the patient's choice of practitioner. The supervising physician must review the medical record of the initial examination or consultation, and ensure that a written report on the initial examination or consultation is furnished to the referring practitioner within ten business days following the completion of the initial examination or consultation.

Section 3. Section 464.012(3), Florida Statutes, is amended to read:

(3) An advanced registered nurse practitioner shall perform those functions authorized in this section within the framework of an established protocol, which shall be filed with the board upon biennial license renewal and within thirty days of entering into a supervisory relationship with a physician or changes to the protocol. The board shall review the protocol to ensure compliance with applicable regulatory standards for protocols. The board shall refer to the department licensees submitting protocols which are not compliant with the regulatory standards for protocols. A practitioner currently licensed under chapter 458, chapter 459, or chapter 466 shall maintain supervision for directing the specific course of medical treatment. Within the established framework, an advanced registered nurse practitioner may:

(a) Monitor and alter drug therapies.

(b) Initiate appropriate therapies for certain conditions.

(c) Perform additional functions as may be determined by rule in accordance with s. 464.003(3)(c).

(d) Order diagnostic tests and physical and occupational therapy.

Section 4. Section 456.041(1)(a), Florida Statutes, is amended to read:

456.041 Practitioner profile; creation.--

(1)(a) The Department of Health shall compile the information submitted pursuant to s. 456.039 into a practitioner profile of the applicant submitting the information, except that the Department of Health shall develop a format to compile uniformly any information submitted under s. 456.039(4)(b). Beginning July 1, 2001, the Department of Health may compile the information submitted pursuant to s. 456.0391 into a practitioner profile of the applicant submitting the information. <u>The protocol submitted pursuant to s. 464.012(3) shall be included in the practitioner profile of the advanced registered nurse practitioner applicant submitting the information.</u>

Section 5. Subsection (6) of section 456.013, Florida Statutes, is amended to read:

456.013 Department; general licensing provisions.--

(6) As a condition of renewal of a license, the Board of Medicine, the Board of Osteopathic Medicine, the Board of Chiropractic Medicine, and the Board of Podiatric Medicine shall each require licensees which they respectively regulate to periodically demonstrate their professional competency by completing at least 40 hours of continuing education every 2 years. The boards may require by rule that up to 1 hour of the required 40 or more hours be in the area of risk management or cost containment. This provision shall not be construed to limit the number of hours that a licensee may obtain in risk management or cost containment to be credited toward satisfying the 40 or more required hours. This provision shall not be construed to require the boards to impose any requirement on

licensees except for the completion of at least 40 hours of continuing education every 2 years. Each of such boards shall determine whether any specific continuing education requirements not otherwise mandated by law shall be mandated and shall approve criteria for, and the content of, any continuing education mandated by such board. Notwithstanding any other provision of law, the board, or the department when there is no board, may approve by rule alternative methods of obtaining continuing education credits in risk management. The alternative methods may include attending a board meeting at which another licensee is disciplined, serving as a volunteer expert witness for the department in a disciplinary case, or serving as a member of a probable cause panel following the expiration of a board member's term. Other boards within the Division of Medical Quality Assurance, or the department if there is no board, may adopt rules granting continuing education hours in risk management for attending a board meeting at which another licensee is disciplined, for serving as a volunteer expert witness for the department in a disciplinary case, or for serving as a member of a probable cause panel following the expiration of a board member's term.

Section 6. Section 456.031, Florida Statutes, is amended to read:

456.031 Requirement for instruction on domestic violence.--

(1)(a) The appropriate board shall require each person licensed or certified under chapter 458, chapter 459, part I of chapter 464, chapter 466, chapter 467, chapter 490, or chapter 491 to complete a 1-hour continuing education course, approved by the board, on domestic violence, as defined in s. 741.28, as part of biennial relicensure or recertification. The course

shall consist of information on the number of patients in that professional's practice who are likely to be victims of domestic violence and the number who are likely to be perpetrators of domestic violence, screening procedures for determining whether a patient has any history of being either a victim or a perpetrator of domestic violence, and instruction on how to provide such patients with information on, or how to refer such patients to, resources in the local community, such as domestic violence centers and other advocacy groups, that provide legal aid, shelter, victim counseling, batterer counseling, or child protection services.

(b) Each such licensee or certificateholder shall submit confirmation of having completed such course, on a form provided by the board, when submitting fees for each biennial renewal.

(c) The board may approve additional equivalent courses that may be used to satisfy the requirements of paragraph (a). Each licensing board that requires a licensee to complete an educational course pursuant to this subsection may include the hour required for completion of the course in the total hours of continuing education required by law for such profession unless the continuing education requirements for such profession consist of fewer than 30 hours biennially.

(d) Any person holding two or more licenses subject to the provisions of this subsection shall be permitted to show proof of having taken one board-approved course on domestic violence, for purposes of relicensure or recertification for additional licenses.

(e) Failure to comply with the requirements of this subsection shall constitute grounds for disciplinary action under each respective practice act and under s. 456.072(1)(k).

In addition to discipline by the board, the licensee shall be required to complete such course.

(2) The board shall also require, as a condition of granting a license under any chapter specified in paragraph (1)(a), that each applicant for initial licensure under the appropriate chapter complete an educational course acceptable to the board on domestic violence which is substantially equivalent to the course required in subsection (1). An applicant who has not taken such course at the time of licensure shall, upon submission of an affidavit showing good cause, be allowed 6 months to complete such requirement.

(3)(a) In lieu of completing a course as required in subsection (1), a licensee or certificateholder may complete a course in end-of-life care and palliative health care, if the licensee or certificateholder has completed an approved domestic violence course in the immediately preceding biennium.

(b) In lieu of completing a course as required by subsection (1), a person licensed under chapter 466 who has completed an approved domestic-violence education course in the immediately preceding 2 years may complete a course approved by the Board of Dentistry.

(4) Each board may adopt rules to carry out the provisions of this section.

(5) Each board shall report to the President of the Senate, the Speaker of the House of Representatives, and the chairs of the appropriate substantive committees of the Legislature by March 1 of each year as to the implementation of and compliance with the requirements of this section.

Section 7. Section 456.033, Florida Statutes, is amended to read:

456.033 Requirement for instruction for certain licensees on HIV and AIDS.--

(1) The appropriate board shall require each person licensed or certified under chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 463; part I of chapter 464; chapter 465; chapter 466; part II, part III, part V, or part X of chapter 468; or chapter 486 to complete a continuing educational course, approved by the board, on human immunodeficiency virus and acquired immune deficiency syndrome as part of biennial relicensure or recertification. The course shall consist of education on the modes of transmission, infection control procedures, clinical management, and prevention of human immunodeficiency virus and acquired immune deficiency syndrome. Such course shall include information on current Florida law on acquired immune deficiency syndrome and its impact on testing, confidentiality of test results, treatment of patients, and any protocols and procedures applicable to human immunodeficiency virus counseling and testing, reporting, the offering of HIV testing to pregnant women, and partner notification issues pursuant to ss. 381.004 and 384.25.

(2) Each such licensee or certificateholder shall submit confirmation of having completed said course, on a form as provided by the board, when submitting fees for each biennial renewal.

(3) The board shall have the authority to approve additional equivalent courses that may be used to satisfy the requirements in subsection (1). Each licensing board that requires a licensee to complete an educational course pursuant to this section may count the hours required for completion of

the course included in the total continuing educational requirements as required by law.

(4) Any person holding two or more licenses subject to the provisions of this section shall be permitted to show proof of having taken one board-approved course on human immunodeficiency virus and acquired immune deficiency syndrome, for purposes of relicensure or recertification for additional licenses.

(5) Failure to comply with the above requirements shall constitute grounds for disciplinary action under each respective licensing chapter and s. 456.072(1)(e). In addition to discipline by the board, the licensee shall be required to complete the course.

(6) The board shall require as a condition of granting a license under the chapters and parts specified in subsection (1) that an applicant making initial application for licensure complete an educational course acceptable to the board on human immunodeficiency virus and acquired immune deficiency syndrome. An applicant who has not taken a course at the time of licensure shall, upon an affidavit showing good cause, be allowed 6 months to complete this requirement.

(7) The board shall have the authority to adopt rules to carry out the provisions of this section.

(8) The board shall report to the Legislature by March 1 of each year as to the implementation and compliance with the requirements of this section.

(9)(a) In lieu of completing a course as required in subsection (1), the licensee may complete a course in end-of-life care and palliative health care, so long as the licensee completed an approved AIDS/HIV course in the immediately preceding biennium.

(b) In lieu of completing a course as required by subsection (1), a person licensed under chapter 466 who has completed an approved AIDS/HIV course in the immediately preceding 2 years may complete a course approved by the Board of Dentistry.

(7) The following requirements apply to each person licensed or certified under chapter 457; chapter 458; chapter 459; chapter 461; chapter 463; part I of chapter 464; chapter 465; chapter 466; part II, part III, part V, or part X of chapter 468; or chapter 486:

(a) Each person shall be required by the appropriate board to complete a continuing education course described in section (1) no later than upon first renewal.

(b) Each person shall submit confirmation described in subsection (2) when submitting fees for first renewal.

(c) Each person shall be subject to subsections (3), (4), and (5).

Section 8. Subsection (3) of section 464.013, Florida Statutes, is amended to read:

464.013 Renewal of license or certificate.--

(3) The board shall by rule prescribe continuing education not to exceed 30 hours biennially as a condition for renewal of a license or certificate. The criteria for programs shall be approved by the board.

Section 9. Subsection (5) of section 458.319, Florida Statutes, is renumbered as subsection (4), and present subsection (4) of that section is amended to read:

458.319 Renewal of license.--

(4) Notwithstanding the provisions of s. 456.033, a physician may complete continuing education on end-of-life care and palliative care in lieu of continuing education in AIDS/HIV,

if that physician has completed the AIDS/HIV continuing education in the immediately preceding biennium.

Section 10. Subsection (5) of section 459.008, Florida Statutes, is amended to read:

459.008 Renewal of licenses and certificates.--

(5) Notwithstanding the provisions of s. 456.033, an osteopathic physician may complete continuing education on end-of-life and palliative care in lieu of continuing education in AIDS/HIV, if that physician has completed the AIDS/HIV continuing education in the immediately preceding biennium.

Section 11. This act shall take effect July 1, 2006.

========== T I T L E A M E N D M E N T ==========

Remove the entire title and insert:

A bill to be entitled

An act relating to health care; amending chapter 458 F.S.; creating ss. 458.348(4), F.S., regarding supervisory relationships in medical office settings; amending chapter 459 F.S., creating ss. 459.024, F.S., regarding formal supervisory relationships, standing orders, and established protocols; notice; standards; amending ss. 464.012(3), F.S., certification of advanced registered nurse practitioners; fees; providing legislative intent; regarding patient care; amending ss. 456.041(1)(a), F.S., practitioner profile; creation; amending ss. 456.013(6), F.S., regarding general licensing privileges; amending section 456.031, F.S., requirement for instruction on domestic violence; amending ss. 456.033 F.S., regarding requirements for instructions for certain licensing on HIV and AIDs; amending ss. 464.013 (3) F.S., regarding renewal of license or certificate; renumbering ss. 458.319(5) as

ss. 458.319 (4), F.S., regarding renewal of license; amending ss. 459.008(5) F.S., regarding renewal of license and certificates; providing an effective date.